Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **New York** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Children's Waiver

C. Waiver Number:NY.4125
Original Base Waiver Number: NY.4125.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
12/01/20

Approved Effective Date of Waiver being Amended: 04/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Expand the definition of Licensed Practitioner of the Healing Arts; Remove duplicate documentation of risk factors after initial eligibility determination; Update the definition of Adaptive and Assistive Technology to remove references to service animals that are not consistent with the ADA (note: the definition will continue to cover reimbursement for service dogs);Clarify the provider qualifications for massage therapy and pain and symptom management.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	Expand the definition of Licensed Practitioner of the Healing Arts; Remove
☐ Appendix A Waiver	

Component of the Approved Waiver	Subsection(s)
Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	Update the definition of Adaptive and Assistive Technology to remove
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☒ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☒ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

1. Request Information (1 of 3)

A. The **State** of **New York** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Children's Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NY.4125
Draft ID: NY.019.05.09

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/17
Approved Effective Date of Waiver being Amended: 04/01/17

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Hospital Level of Care for Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160 is also included in this waiver but the selection is not permitted by the portal"

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☒ **A program authorized under §1115 of the Act.**

Specify the program:

CMS approved New York's request to amend its section 1115(a) demonstration titled, "Medicaid Redesign Team" (MRT) (Project Number 11-W-001142/2} on August 2, 2019. The approval enabled the state to create a streamlined children's model of care for children and youth under 21 years of age with behavioral health (BH) and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities.

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The New York State (NYS) amendment of the Children's waiver will operate concurrently with the State's 1115 MRT waiver. The New York State (NYS) amendment of the Children's waiver began on April 1, 2019 consistent with the Transition Plan in Attachment A-1.

Beginning 10/1/2019, the Children's waiver will operate concurrently with the State's 1115 MRT waiver. HCBS services will be provided by the MCOs for children in managed care beginning October 1, 2019. Children in FFS will continue to receive HCBS via the FFS delivery system. The Children's Medicaid waiver includes specifically:
- Incorporates the Serious Emotional Disturbance (SED), Medically Fragile, and foster care and medically fragile Developmental Disability (DD) target populations.
- Incorporates the aligned HCBS descriptions and provider qualifications into this waiver
- Includes all levels of care (hospital, nursing facility, and ICF/IIID).
-Includes the use of an algorithm based on a subset of the CANS-NY, housed in the Uniform Assessment System (UAS-NY) for all community-based programs for hospital and nursing facility LOC. ICF-IID LOC determinations will continue to be made utilizing the DDRO ICF-IID determination tool. Please refer to Section B-6 (c-d).
-Includes case management descriptions from the State's Health Home SPA for children and provides an administrative alternative to Health Home for children who opt out of Health Homes through the State's Independent entity.
-Three year phase in of HCBS Level of Care (LOC) slots (i.e., removal of waiting list, expansion of HCBS). This will necessitate the temporary implementation of "slots" in this waiver with an expansion as outline in the Attachment #1 to Appendix B-3

As of October 1, 2019, the Children's Waiver will operate concurrently with a managed-care authority via the CMS approved 1115(a) demonstration titled, "Medicaid Redesign Team" (MRT) (Project Number 11-W-001142/2}. The concurrent implementation of the 1115(a) demonstration will create a streamlined model of care for children and youth under 21 years of age with BH and HCBS needs, including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities, by allowing managed care authority for their HCBS. The concurrent authorities will improve health outcomes for children and youth with BH and HCBS needs by addressing needs early in childhood and before they escalate and become more costly and complex in adulthood. The concurrent 1115 Demonstration will also integrate the delivery and care planning of behavioral and physical health and community supports, and increase network capacity.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source,

including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

NYSDOH staff and state agency partners work closely on a continuing basis with advocacy groups for families of children with disabilities and waiver service providers. A service provider summary of the MRT meetings since 2011 can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/web-info_child_mst.htm

The original 1115 waiver notice of the concurrent operation of children's HCBS in managed care was noticed on July 5, 2017.

The State published the entire 1915(c) waiver amendment and the notice on June 15, 2020 at the following website: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm

The State published public notice from June 19, with a date clarification on June 15,2020, for 30 days in the New York State Register for this amendment .

Both notices included an address to submit comments to the Department of Health. No comments were submitted

Pursuant to Presidential Executive Order #13175, NYSDOH provided the State's nine federally recognized Tribal Governments with written notification of the children's waiver application and all proposed substantial changes to the program and offered an opportunity for their comment. Notice to the tribes was sent to the tribes on June 15, 2020, regarding this specific amendment. The notice included an address to submit comments to the Department of Health. No comments were submitted.

Public Notice:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/proposed_hcbs_waiver_%20NY.4125.R

Public Notice Responses received: 14
Component(s) of the Approved Waiver Affected by the Amendment:
• The definition of a Licensed Practitioner of the Healing Arts for the purposes of determining risk factors for Children's Waiver eligibility is expanded to include licensed practitioners who have the ability to diagnose within his or her scope of practice under the state law or who are under the supervision of another licensed practitioner of the healing arts who has the ability to diagnose within his/her scope of practice under State law.
o All comments received support efforts to expand the definition of Licensed Practitioner of the Healing Arts and therefore expand the network of practitioners able to determine eligibility for Children's Waiver Services.
• Public comments also included requests to amend the scope of practice in NYS Education Law Article 163. The State will explore this suggestion for a possible future amendment.
• After a child is found to meet Children's Waiver eligibility including the existence of a risk factor, the State will not require on-going documentation of the existence of the LPHA risk factor so long as the child is continuously eligible for the waiver (i.e., continues to meet target criteria and level of care criteria).
o All comments received support the reduction of documentation and effort made by the State to reduce barriers and enable children to access care. One comment requested that annual waiver level of care determinations be discontinued; however, that is not permissible under federal requirements.

• The State will update the definition of Adaptive and Assistive Technology to remove references to service animals that are not consistent with the ADA.
o Public comment supported this change and, in some cases, indicated that the change was nonissue.

• The State will reduce payments for services by 1.5% on or after September 1, 2020 consistent with the approved state budget. Note: the State has already submitted an amendment to reduce payments for services by 1% on or after March 1, 2020 and by an additional 0.5% (for a total reduction of 1.5%) on or after April 2, 2020 consistent with the approved state budget.
o Commenters expressed concern that reducing payments for Home and Community Based Services will reduce access to services and negatively affect providers' ability to sustain service delivery. The final submission of this amendment removes the request to apply this payment reduction.

• The State will update the provider specifications for Palliative Care: Massage therapy to include provider agencies

meeting the interagency provider designation requirements.
o Public response supported this change and in some cases the response indicated that the change was a nonissue.

• The State will update the practitioner qualifications for Palliative Care: Pain and Symptom Management to include a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medical physician, board certified in Pediatrics.
o Public response supported this change and in some cases the response indicated that the change was a nonissue.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Janet

First Name: Zachary Elkind

Title: Deputy Director

Agency: New York State Department of Health, Office of Health Insurance Programs

Address: One Commerce Plaza

Address 2: Room 720

City: Albany

State: **New York**

Zip: 12237

Phone: (518) 473-5452 **Ext:** ☐ **TTY**

Fax: (518) 486-2495

E-mail: Janet.zachary-elkind@health.ny.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Greg

First Name: Allen

Title: Director, Division of Program Development & Management

Agency: NYS Department of Health, Office of Health Insurance Programs

Address: One Commerce Plaza

Address 2: Room 720

City: Albany

State: **New York**

Zip: 12237

Phone: (518) 473-0919 **Ext:** ☐ **TTY**

Fax: (518) 486-1346

E-mail: gregory.allen@health.ny.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Frescatore

First Name: Donna

Title:

Deputy Commissioner/Medicaid Director

Agency:

New York State Department of Health, Office of Health Insurance Programs

Address:

One Commerce Plaza, 99 Washington Avenue

Address 2:

Room 1211

City:

Albany

State: **New York**

Zip:

12237

Phone:

(518) 486-1346 **Ext:** ☐ **TTY**

Fax:

(518) 486-1346

E-mail:

donna.frescatore@health.ny.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Timeline for Transitioning a single 1915(c) waiver and Managed Care provision of HCBS for children enrolled in MCOs Date

1. General Notice to Children Enrolled in Six 1915(c) Waivers
-November 15, 2018

2. 30 Day notice to individual members to transition 1915(c) individual waivers to 1915(c) consolidated Children's waiver. This notice includes the HCBS changes.
-January 29, 2019

3. Transition members currently enrolled in each of the six 1915(c) waivers identified in this waiver application under section II purpose of the amendment to Health Home care management.

4. Any change in services would be an action and can be appealed. The Consolidation of the waiver is not an action and cannot be appealed. Participants will be informed of their right to appeal when the new Plan of Care using the new service names, units, and rate codes are developed and will be granted a right to appeal if they believe that a service requested is being changed to their detriment. All participants will receive their appeal rights at the time of the development of their new Plan of Care as part of the Plan of Care process. However, no services currently being received will be terminated or reduced as a result of the consolidation of this waiver. The termination of the waivers is a change in State law and regulation per 42 CFR 431.220(b). Participants cannot appeal the consolidation of waivers.

5. All participants in the current 1915(c) waivers will be eligible to receive the same services under EPSDT and the new combined waiver.

6. SED waiver only - To ensure continuity of care, until April 1,2019, the ICC agency is responsible for continuing to provide HCBS to an enrolled child, including submitting claims to Medicaid for reimbursement on behalf of their subcontractors under the Waiver's OHCDS authority. This is the case even after that child transitions his or her care management from this 1915(c) waiver to the Health Home State Plan or the Independent Entity. The ICC Agency, as an OHCDS, will submit claims to the eMedNY system for all HCBS following historical billing guidance for all HCBS services provided on or before March 31, 2019. For HCBS services provided April 1, 2019 moving forward, the ICC will no longer be responsible for submitting claims for subcontractors for any HCBS. This will ensure that HCBS providers are reimbursed without having to modify the eMedNy system to process historical coding that will be obsolete beginning 4/1/2019. It also allows the Waiver ICC to focus on a systemic case by case transfer to allow POC to be cross-walked to the Children's waiver coding POC PRIOR to effective date of enrollment, and transition to health homes and the IE. - January 1, 2019 to March 31, 2019

7. 1915(c) Children's Waiver implemented – new array of aligned HCBS, Children in HCBS eligible for Health Home care management or Independent Entity. Transition all members currently enrolled in each of the six 1915(c) waivers identified in this waiver application to this consolidated Children's waiver. There will be no children currently eligible for HCBS who will not be eligible under the Children's waiver. All services provided under the six former 1915(c) waivers will continue to be provided to HCBS children through either the State Plan (#17-004 and #19-0003) or this HCBS waiver authority. See crosswalk to the new service names below. There is no reduction in the amount, duration or scope of the HCBS between the former and future authorities. Any limitations in this waiver are in excess of the former limits permitted under the historic waivers.- April 1, 2019

8. Three year phase in of HCBS Level of Care (LOC) slots (i.e., removal of waiting list, expansion of HCBS). This will necessitate the temporary implementation of "slots" in this waiver with an expansion as outline in the Attachment #1 to Appendix B-3. All slots at a given point in time are anticipated to be phased out July 1, 2022.
- July 1, 2019- July 1, 2022

9. Approval of the 1115 MRT waiver permitting enrollment of children in HCBS in managed care– August 2, 2019
10. Enrollment notices and choice packages are sent to children receiving HCBS who are eligible but not yet enrolled in managed care –August 16, 2019
11. Children receiving HCBS are enrolled in managed care – October 1, 2019

1915(c) Waiver Services to State Plan and Children's 1915(c) Waiver Service Crosswalk Existing CAH I/II Waiver Services crosswalk to the following services:
-Care Coordination crosswalks to State Plan Health Home, or Administrative claim for the Independent Entity
-Respite Care crosswalks to Respite in the Children's waiver amendment
-Home and Vehicle Modifications crosswalks to Environmental Modifications and Vehicle Modifications in the Children's

waiver amendment
-Palliative Care (Bereavement Service, Massage Therapy, Expressive Therapy, Family education) crosswalk to Palliative Care (Bereavement Service, Massage Therapy, Expressive Therapy) Children's waiver amendment
-Pain & Symptom Management is a new related Palliative service in the Children's waiver amendment

Existing OCFS B2H Waiver Services cross walks to the following services:
-Immediate Crisis Response Services crosswalks to in the Children's waiver through 1/1/2020 and then to the new EPSDT Crisis Intervention SPA.
-Crisis Avoidance, Management & Training AND Intensive In-Home Services crosswalks to the new EPSDT Community Psychiatric Supports & Treatment SPA.
-Skill Building crosswalks to EPSDT Psychosocial Rehabilitation Services SPA.
-Health Care Integration crosswalks to the Health Home, or administrative claim for Independent Entity.
-Crisis & Planned Respite crosswalks to Respite in the Children's waiver amendment
-Prevocational Services crosswalks to Prevocational Services in the children's waiver amendment.
-Family/Caregiver Support Services crosswalks to Caregiver/Family Support & Services in the Children's waiver amendment
-Supported Employment crosswalks to the Supported Employment in the Children's waiver amendment
-Special Needs Community Advocacy and Support (SNCAS) crosswalks to Community Self-Advocacy Training and Support in the Children's waiver amendment
-Day Habilitation crosswalks to Day Habilitation and Community Habilitation in the Children's waiver amendment
-Adaptive and Assistive Equipment crosswalks to Adaptive and Assistive Equipment in the Children's waiver amendment
-Accessibility Modifications crosswalks to Environmental Modifications and Vehicle Modifications in the Children's waiver amendment

Existing OPWDD CAH Waiver Services crosswalks to the following services:
--Case Management crosswalks to Health Home in the SPA, or Administrative Claiming with the Independent Entity.
-Respite crosswalks to Respite in the Children's waiver amendment.
-Assistive Technology – Adaptive Devices crosswalks to Adaptive and Assistive Equipment in the Children's waiver amendment.
-Environmental Modifications (Home Accessibility) crosswalks to Environmental Modifications and Vehicle Modifications in the Children's waiver amendment.

Existing OMH SED Waiver Services crosswalks to the following services:
-Crisis Response Services crosswalks to Crisis Intervention in the Children's waiver through 1/1/2020 and then to in the new EPSDT SPA.
-Intensive In-Home Services crosswalks to Community Psychiatric Supports & Treatment in the new EPSDT SPA.
-Family Peer Support Services crosswalks to Family Peer Support Services in the new EPSDT SPA.
-Youth Peer Advocacy and Training crosswalks to Youth Peer Advocacy and Training in the Children's waiver through 1/1/2020 and then to in the new EPSDT SPA.
-Skill Building crosswalks to Psychosocial Rehabilitation Services in the new EPSDT SPA.
-Individualized Care Coordination and Transitional Case Management crosswalks to Health Home in the SPA or Administrative Claiming with the Independent Entity
-Respite Services crosswalks to Respite in the children's waiver amendment.
-Prevocational Services crosswalks to Prevocational Services in the children's waiver amendment.
-Supported Employment crosswalks to Supported Employment in the children's waiver amendment.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not

necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this Waiver amendment or renewal will be subject to any provisions or requirements included in the State's most recent and/or approved Home and Community-Based Settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the Home and Community-Based Settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

◉ **The Medical Assistance Unit.**

Specify the unit name:

Office of Health Insurance Programs

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

For enrollees in FFS, Health Homes assess children and conduct plan of care development and carry out the plan of care that supports the child's functional development and inclusion in the community. For children who opt out of Health Homes, the State's Independent Entity performs these functions. An Independent Evaluator at the Independent Entity meeting the qualifications outlined in Appendix B-6 will conduct the level of care evaluation and re-evaluation for opt-out children. For Family of One children who are not eligible for Medicaid yet or children who opt out of Health Homes, the State's Independent Entity performs functions related to the functional eligibility determination and plan of care development as well as contacting the child/family periodically to monitor the implementation of the POC. Once the child is eligible for Medicaid, the child will select a Health Home or opt-out into the Independent Entity for HCBS case management. For FFS participants who are not in managed care, the State's Independent Entity will participate in the on-going review of participant level of care assessment; participation in the development of and review of the functional eligibility determination resulting in a POC; and authorization of participation in the waiver for applicants who qualify. Health Homes and IE will refer applicable children to the DDRO for ICF-IID LOC determination and will enter the information in the UAS. After DDRO review, Health Home or IE will confirm that the child's LOC meets the HCBS eligibility qualifications. The child's application is part of the UAS subject to NYSDOH staff review. The LDSS will perform any financial eligibility steps necessary to finalize HCBS eligibility. NYSDOH or its designee will send a letter of approval or denial which is addressed to child/family. All subsequent evaluations and assessments maintained at the Health Home or IE for those children that opt out of HH and subject to NYSDOH review.

The HHCM or IEIE for children opting out of the HH monitors and oversees the implementation of the POC through frequent communication with parents/legal guardians.

For enrollees in managed care, the state's contracted Managed Care Organizations (MCOs) are responsible for contracting with Health Homes that assess children and conduct plan of care development and carry out the plan of care that supports the child's functional development and inclusion in the community. For children who opt out of Health homes, the State's Independent Entity will conduct the assessment and develop the Plan of Care. The MCO Care Coordinator will contact the child/family periodically to monitor the implementation of the POC. The IE will provide the MCO with the Plan of Care. Health Homes and IE will refer applicable children to the DDRO for ICF-IID LOC determination. The child's MCO will ensure related service authorizations are in accordance with the Plan of Care, review POCs, assist with utilization management by reviewing the POC to ensure that all assessed needs are met and that the POC complies with federal requirements, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the MRT program including this waiver. The State's External Quality Review Organization will perform managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E. The HHCM or IEIE for children opting out of the HH monitors and oversees the implementation of the POC through frequent communication with parents/legal guardians. The MCO also reviews the POC for managed care enrollees.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Developmental Disability Regional Office (DDRO) will have UAS-NY eligibility access to complete the ICF/IID LOC for children requiring that LOC. The DDRO will refer the child back to the HH or IE for the plan of care development. DOH reviews MA regulatory and operational functions for the DDRO LOC determinations through the in consultation with other DOH Divisions including the Division of Legal Affairs as needed.

In New York State, the Local Departments of Social Services (LDSS) and Human Resource Administration (HRA) in New York City will continue to conduct financial eligibility determinations.

The respective roles and responsibilities of the State and the LDSS are established by Sections 201 and 206 of the Public Health Law, Sections 363-a and 366.6 of the Social Services Law, and by the Medicaid (MA) State Plan. In addition, NYS bulletins, General Information Systems (GIS), and MA Management Administrative Directives (ADM) are issued and updated as needed to provide ongoing guidance regarding MA program administration. Accordingly, no additional Memorandum of Understanding between the State and an LDSS is necessary. This includes HRA, which covers New York City's five boroughs.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS delivery system and is, accordingly, responsible for oversight of Health Home program, including standards requirements and roles and responsibilities. OHIP is also responsible for the performance of the Independent Entity.

The OHIP managed care staff are responsible for the day-to-day operation and oversight of the Children's MC delivery system and are accordingly responsible for assessing the performance of the MCO waiver administration which includes the roles and responsibilities of Health Homes contracted by MCOs. The State's External Quality Review Organization will perform managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E.

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DOH OHIP in conjunction with other DOH divisions assess the performance of the contractor's participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative.

The DOH FMG monitors funds spent on the waiver using the audit pool and performance measures and 95% CI sampling methodology outlined in Appendix I-1.

DOH has regular meetings with the MCOs, Independent Entity, and Health Homes to discuss MCO and FFS reports, fiscal and program data and HCBS assurance data.

DOH conducts annual site visits at each MCO to assess the plan's performance including oversight of the MCOs enrollment processes, ensuring that the MCO has utilization procedures and prior authorization processes in place to review waiver expenditures against approved levels, credentialing of providers, and quality assurance and quality improvement activities.

The State's External Quality Review Organization will perform annual managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E as well as other managed care regulations.

The DOH, through its annual sample of POCs checks for signatures and timeliness of assessments, as well as for review and sign off on level of care certifications for the MCOs, Health Homes and Independent Entity. NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the MCO/Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. All applications along with the level of care determinations are entered in the UAS, and participant POCs are submitted to the MCO and maintained by the HH/IE and subject to NYSDOH review. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

The Health Home and IE are required to maintain information in the State's database that tracks information regarding applications, authorized participants, dis-enrolled participants, and applicants denied waiver participation. Health Home and IEs are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services. These reports and records are used to assess waiver administrative performance.

Health Home Care Managers, MCOCC, and IE Independent Evaluators (IEIE) and NYSDOH will track and trend complaints/grievances received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes and the IE are responsible for investigating and responding to complaints that are received.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125) and managedcarecomplaint@health.ny.gov. The OHIP Division of Health Plan Contracting and Oversight operates a complaint system that accepts complaints from enrollees, their designees and providers regarding the access to and quality of care received. The MCOs are also required under 438 Subpart F to maintain a complaint and Grievance system outlined in Appendix F of this document. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO and LDSS oversight as needed. DOH staff receives a copy of complaints and conferences with the Health Home/IE to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home/IE and the complainant if NYSDOH staff determines that the situation warrants it.

NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home/MCO /IE and investigate complaints. For example, quarterly conference call meetings with the Health Home/MCO /IE staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home/MCO/IE staff.

NYSDOH staff participate in training and other meetings such as the statewide MCO and Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and/or percent of aggregated performance measure (PM) reports generated by the HH/MCO/IE and reviewed by the DOH that contain discovery, remediation, and system improvement for on-going compliance of the assurances (Percentage = HH/MCO/IE PM reports reviewed with system improvement data/total number of HH/MCO/IE PM reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Performance Measure reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: HH,MCO, and Independent Entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH/MCO/ and Independent Entity	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and/or percent of HH, MCO, and IE administrative and quality assurance reports approved by DOH prior to implementation by the HH,MCO, or IE. (Percentage = HH/MCO/IE reports approved prior to implementation by the HH,MCO, and IE/total number of IE reports)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative and quality reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

HH,MCO, or Independent Entity		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH,MCO, and Independent Entity	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Tracking reports:
Monthly reports from Health Homes/MCOs/IE are used as a tracking tool to monitor program activity. Many reports can be pulled directly from the State's Medicaid Analytics Performance Portal (MAPP) and Uniform Assessment System (UAS) by OHIP staff.

Conference calls:
Regular conference calls enable the sharing and peer discussion of HCBS issues. NYSDOH staff may also present new directives or waiver topics.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH/IE or NYSDOH staff or Interagency Monitoring Team, which is chaired by NYSDOH, identifies a lack in the quality of provided services or any other issue related to administration of waiver services including performance of a contractor or Local/Regional Non-State Entity. If the contract manager, or NYSDOH as a whole, discovers and documents a repeated deficiency in performance of the contractor, MCO or Local/Regional non-State Entity, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of invoiced payment compensation or other actions outlined in each contract. General methods for problem correction include revisions to state contract terms based on lessons learned.

In such situations, the standard procedure is for NYSDOH staff and the Interagency Monitoring Team to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The contractor, MCO, or Local/Regional Non- State Entity must provide a plan of correction. NYSDOH staff and the IMT may collaboratively work to develop a plan of correction with the contractor, MCO, and/or or Local/Regional Non- State Entities if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HH Care Manager (HHCM) or IEIE will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency also involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. Accordingly, NYSDOH staff will issue a letter to the provider terminating the provider's waiver designation provider status.

Unsatisfactory accessibility modification and adaptive and assistive equipment contractors will be notified of their disqualification from further service by the administering MCO, LDSS or DDRO. The HHCM or IEIE will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO, IE staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO, IE and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

Unsatisfactory home and vehicle modification contractors will be notified of their disqualification from further service by the administering MCO or the NYDOH for FFS. The HHCM/IEIE/MCOCC will help the family find alternate contractors and craftsmen.

Documentation of remediation activities is accomplished by the following measures: correspondence between NYSDOH waiver management staff, the HH/IE, participants and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families; MCO monitoring results, and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file and, as appropriate, by NYSDOH.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: MCO/Independent Entity/Health Home	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	20	
	☒	**Disabled (Other)**	0	20	
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	0	20	☐
	☒	**HIV/AIDS**	0	20	☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	**Medically Fragile**	0	20	☐
	☒	**Technology Dependent**	0	20	☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0	20	☐
	☒	**Developmental Disability**	0	20	☐
	☒	**Intellectual Disability**	0	20	☐
☒ **Mental Illness**					
	☒	**Mental Illness**	18	20	☐
	☒	**Serious Emotional Disturbance**	0	18	

b. Additional Criteria. The state further specifies its target group(s) as follows:

LPHA FORMS
1. Serious Emotional Disturbances (SED) LOC population:
a. Target Criteria
1. Ages 0 to their 21st birthday and

2. The child has a serious emotional disturbance (SED). SED means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis, as determined by a licensed mental health professional.

3. SED is defined to include any one of the DSM diagnoses:

a. Schizophrenia Spectrum and Other Psychotic Disorders
b. Bipolar and Related Disorders
c. Depressive Disorders
d. Anxiety Disorders
e. Obsessive-Compulsive and Related Disorders
f. Trauma- and Stressor-Related Disorders
g. Dissociative Disorders
h. Somatic Symptom and Related Disorders
i. Feeding and Eating Disorders
j. Disruptive, Impulse-Control, and Conduct Disorders
k. Personality Disorders
l. Paraphilic Disorders
m. Gender Dysphoria
n. Elimination Disorders
o. Sleep-Wake Disorders
p. Sexual Dysfunctions
q. Medication-Induced Movement Disorders
r. Attention Deficit/Hyperactivity Disorders
s. Tic Disorders

b. Risk Factors – The child meets one of the factors 1–4 as well as factor 5.
1. The child is currently in an out-of-home placement, including psychiatric hospital, or

2. The child has been in an out-of-home placement, including psychiatric hospital within the past six months, or

3. The child has applied for an out-of-home placement, including placement in psychiatric hospital within the past six months, or

4. The child currently is multi-system involved (i.e., two or more systems) and needs complex services/supports to remain successful in the community, AND

5. A licensed practitioner of the healing arts (LPHA), who has the ability to diagnose within his/her scope of practice under State law or who is under the supervision of another licensed practitioner of the healing arts who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child, in the absence of HCBS is at risk of institutionalization (i.e., hospitalization). The LPHA has submitted written clinical documentation to support the determination. Once enrolled, the risk criteria including the LPHA determination does not need to be re-established so long as the child continues to meet targeting and functional criteria (no break in coverage permitted) up to their 21st birthday.
Out of-home placement in LOC Risk Factor #1–4 includes: RRSY, RTF, RTC, or other congregate care setting, such as SUD residential treatment facilities, group residences, institutions in the OCFS system or hospitalization.

Multi-system involved means two or more child systems including: child welfare, juvenile justice, OASAS clinics or residential treatment facilities or institutions, OMH clinics or residential facilities or institutions, OPWDD services or residential facilities or institutions, or having an established IEP through the school district.

2. Medically Fragile LOC population:
a. Target Criteria
1. Ages 0 to their 21st birthday Note: MF children may optionally transition to MLTC on their 18th birthday.

2. The child must have a documented physical disability following state demonstration protocols.
i. Current SSI Certification or

ii. DOH-5144 or
iii. Forms: OHIP 0005, OHIP 0006 and OHIP 0007 completed by appropriate professionals and caregivers to be reviewed and approved by an LPHA

b Risk Factor
1. A LPHA who as the ability to diagnose within his or her scope of practice under the state law or who is under the supervision of another licensed practitioner of the healing arts who has the ability to diagnose within his/her scope of practice under State law, has determined in writing that the child, in the absence of HCBS, at risk of institutionalization (i.e., hospitalization, ICF-ID or nursing facility). The LPHA has submitted written clinical documentation to support the determination. . Once enrolled, the risk criteria including the LPHA determination does not need to be re-established so long as the child continues to meet targeting and functional criteria (no break in coverage permitted) up to their 21st birthday.

3. Developmental Disability LOC population who are Medically Fragile:
a. Target Criteria

1. Ages 0 to their 21st birthday
2. Medically Fragile as defined by subset of questions from CANS-NY Algorithm
3. Child has developmental disability as defined by OPWDD which meets one of the criteria a–c as well as criteria d and e
a. Is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism, or
b. Is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children, or
c. Is attributable to dyslexia resulting from a disability described above; and originates before such child attains age 22; and
d. Has continued or can be expected to continue indefinitely; and
e. Constitutes a substantial handicap to such child’s ability to function normally in society.
b. Risk Factor
The child must be Medically Fragile as demonstrated by a Licensed Practitioner of the Healing Arts(LPHA) who has the ability to diagnose within his/her scope of practice under the state law or who is under the supervision of another licensed practitioner of the healing arts who has the ability to diagnose within his/her scope of practice under State law, has determined in writing, that the child in the absence of HCBS, is at risk of institutionalization (i.e., hospitalization, ICF-IDD or nursing facility). The LPHA has submitted written clinical documentation to support the determination. Once enrolled, the risk criteria including the LPHA determination does not need to be re-established so long as the child continues to meet targeting and functional criteria (no break in coverage permitted) up to their 21st birthday.

4. Developmental Disability LOC population who are in or were formerly in Foster Care: a. Target Criteria
1. Ages 0 to their 21st birthday

2. Child has developmental disability as defined by OPWDD which meets one of the criteria a–c as well as criteria d and e.
a. Is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism, or
b. Is attributable to any other condition of a child found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior of a child with intellectual disability or requires treatment and services similar to those required for such children, or
c. Is attributable to dyslexia resulting from a disability described above; and originates before such child attains age 22; and

d. Has continued or can be expected to continue indefinitely; and
e. Constitutes a substantial handicap to such child's ability to function normally in society.

b. Risk Factor
1. The child must be either: 1) a current FC child in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) or 2) a FC child who enrolled in HCBS originally while in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY). Once enrolled, eligibility can continue after the child is discharged from LDSS and OCFS DJJOY custody so long as the child continues to meet targeting, risk and functional criteria (no break in coverage permitted) up to their 21st birthday.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Eligibility for Children's Waiver ends on the day of the waiver participant's twenty-first birthday. As physically disabled participants reach their seventeenth (17) birthday, the HH/IE will begin to assist the enrollees in planning for transition to other services and/or programs. Waiver enrollees with physical disabilities who reach their eighteenth (18) birthday may transition to Medicaid managed care or to another HCBS waiver that serves adults, such as the Nursing Home Transition and Diversion (NHTD) waiver or the Traumatic Brain Injury (TBI) waiver, as available and/or appropriate. It should be noted that the Children's waiver allows these children to continue receiving waiver services until their 21st birthday, if needed.

For Foster Care enrollees, eighteen months prior to reaching the enrolled child's 21st birthday, the Health Home/IE generates a Transition Plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for conducting the action steps. This Transition Plan outlines the ongoing Medicaid State Plan and waiver services that may be accessed from another Home and Community Based Services (HCBS) authority that offers appropriate services. This Transition Plan requires an evaluation of the participant for adult services. An essential component of transition planning is verifying that all necessary eligibility and/or assessment information is current and accurate to facilitate the child's transition from the waiver to appropriate adult services. It should be noted that the waiver allows these children to continue receiving waiver services until their 21st birthday, if needed.

The Children's Waiver package of services is not comparable to the adult system because their needs differ significantly. Waiver participants are eligible to receive all services until they are discharged from the waiver. The POC for youth over age 14 must include goals developing a participant's capacity live independently and the identification of available resources. When the youth transitions from the waiver, the MCO (for managed care enrollees) and the HH/IE (for FFS enrollees) will be responsible for preparing a POC and making referrals, which will assist in transitioning the participant to adult services and resources.

The POC and necessary referrals to adult services is used by the MCO/HH/IE to document follow-up needed and for future MCO care coordinators (MCOCC) or HHCM with continuing responsibility following discharge from the HCBS waiver to ascertain that discharge services are implemented, and if not, what actions need to be taken.

The MCOCC, HHCM or IEIE is responsible for all documentation and for coordinating services following a child's departure from the HCBS waiver. At a minimum, the MCOCC, HHCM or IEIE is required to contact the family to assure that services are operative and to summarize the participant and family's status at the first two week and four-week intervals. The MCOCC, HHCM or IEIE intervenes as appropriate if problems are noted and continues documenting in the POC.

If the child continues to meet the targeting, risk and LOC determination under the 1915(c) Children's waiver and requests a service on the 1915(c) Children's waiver that is not on one of the adult waivers such as the Nursing Home Transition and Diversion (NHTD) waiver or the Traumatic Brain Injury (TBI) waiver, the child will be permitted to remain on the Children's waiver. A transition plan will be developed to transition this child to the adult waivers

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

- ( ) **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1600
Year 2	1755
Year 3	11649
Year 4	14515
Year 5	17379

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*

:

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1600
Year 2	1755
Year 3	9313
Year 4	11604
Year 5	13894

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Crisis Slots (10% of OMH and OCFS SED)
Children transitioning and/or eligible for the former Children's Medically Fragile ICF-IID waiver
Children transitioning and/or eligible for the former Children's I/II or B2H MF waiver
Children transitioning and/or eligible for the former the B2H DD waiver

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Crisis Slots (10% of OMH and OCFS SED)

Purpose *(describe):*

The State is reserving capacity to ensure that children transitioning from the former children's waivers will have at least the same access to care as today through the transition to July 1, 2022 when the waiting list is anticipated to be completely removed.

Describe how the amount of reserved capacity was determined:

The methodology uses the 2018 existing slots, projects forward the expected growth in the number of new 1915(c) slots and reevaluates the methodology on an annual basis to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	464
Year 4	464
Year 5	464

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children transitioning and/or eligible for the former Children's Medically Fragile ICF-IID waiver

Purpose *(describe):*

The State is reserving capacity to ensure that children transitioning from the former children's waivers will have at least the same access to care as today through the transition to July 1, 2022 when the waiting list is anticipated to be completely removed.

Describe how the amount of reserved capacity was determined:

The methodology uses the 2018 existing slots, projects forward the expected growth in the number of new 1915(c) slots and reevaluates the methodology on an annual basis to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	520
Year 4	520
Year 5	520

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children transitioning and/or eligible for the former Children's I/II or B2H MF waiver

Purpose *(describe):*

The State is reserving capacity to ensure that children transitioning from the former children's waivers will have at least the same access to care as today through the transition to July 1, 2022 when the waiting list is anticipated to be completely removed.

Describe how the amount of reserved capacity was determined:

The methodology uses the 2018 existing slots, projects forward the expected growth in the number of new 1915(c) slots and reevaluates the methodology on an annual basis to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	1900
Year 4	1900
Year 5	1900

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children transitioning and/or eligible for the former the B2H DD waiver

Purpose *(describe):*

The State is reserving capacity to ensure that children transitioning from the former children's waivers will have at least the same access to care as today through the transition to July 1, 2022 when the waiting list is anticipated to be completely removed.

Describe how the amount of reserved capacity was determined:

The methodology uses the 2018 existing slots, projects forward the expected growth in the number of new 1915(c) slots and reevaluates the methodology on an annual basis to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0

Waiver Year	Capacity Reserved
Year 2	0
Year 3	541
Year 4	541
Year 5	541

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

○ **The waiver is not subject to a phase-in or a phase-out schedule.**

◉ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

○ **Waiver capacity is allocated/managed on a statewide basis.**

◉ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

The waiver capacity is allocated/managed on a statewide basis by NYSDOH. The slots are not allocated to any local/regional non-state entity. However, until 2022, the State will use 5 regional targets to ensure that all regions have equitable access to children's HCBS. The methodology uses the 2018 existing slots, projects forward the expected growth in the number of new 1915(c) slots and reevaluates the methodology on an annual basis or as needed to ensure that there is not a surplus of unused capacity among the regions. There will be no wait list for Medically Fragile children. There is no wait-list for this waiver as of 3/15/2020 for any population.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Children's waiver provides enrollment for eligible children who must be under 21 years of age, require the level of care provided in a nursing facility, ICF/IID or hospital, and be capable of being cared for in the community if provided with HCBS under this waiver.

Enrollment is based on first come first served if there is no waiting list. If no Waiver slots are available, all children will be placed on a wait list. While on the wait list, the Community eligible Medicaid applicant's needs are managed through other services until there is an opening in the waiver. Once referred to Health Home, the Health Home is responsible for ensuring that the child is eligible under the Waiver. If a child is in crisis and waiver services would divert an institutionalization or waiver services would reduce the length of a current institutionalization, then the child is eligible for a reserved crisis waiver slot based upon notification of the availability of a crisis slot from NYSDOH. NYSDOH will manage the wait list for any Family of One child who cannot receive Medicaid services until there is a waiver slot for the child.

As of 3/15/2020, there is no wait-list for the waiver or Health Homes. It is not anticipated that Health Homes will have a wait-list.

Total Enrollment (filled) as of January 2, 2020 - 6,737
Total Number of Currently Available Slots - 2,004

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 04/01/17

a. The waiver is being (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 1600

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 1600

Month	Base Number of Participants	Change	Participant Limit
Apr	1600	0	1600
May	1600	0	1600
Jun	1600	0	1600
Jul	1600	0	1600
Aug	1600	0	1600
Sep	1600	0	1600
Oct	1600	0	1600
Nov	1600	0	1600
Dec	1600	0	1600
Jan	1600	0	1600
Feb	1600	0	1600
Mar	1600	0	1600

Waiver Year 2
Unduplicated Number of Participants: 1755

Month	Base Number of Participants	Change	Participant Limit
Apr	1600	155	1755
May	1755	0	1755
Jun	1755	0	1755
Jul	1755	0	1755
Aug	1755	0	1755
Sep	1755	0	1755
Oct	1755	0	1755
Nov	1755	0	1755
Dec	1755	0	1755
Jan	1755	0	1755
Feb	1755	0	1755
Mar	1755	0	1755

Phase-In/Phase-Out Schedule

Waiver Year 3

Month	Base Number of Participants	Change	Participant Limit
Apr	1755	5840	7595
May	7595	0	7595
Jun	7595	0	7595
Jul	7595	191	7786
Aug	7786	191	7977
Sep	7977	191	8168
Oct	8168	191	8359
Nov	8359	191	8550
Dec	8550	191	8741
Jan	8741	191	8932
Feb	8932	191	9123
Mar	9123	190	9313

Waiver Year 4

Unduplicated Number of Participants: 14515

Month	Base Number of Participants	Change	Participant Limit
Apr	9313	191	9504
May	9504	191	9695
Jun	9695	191	9886
Jul	9886	191	10077
Aug	10077	191	10268
Sep	10268	191	10459
Oct	10459	191	10650
Nov	10650	191	10841
Dec	10841	191	11032
Jan	11032	191	11223
Feb	11223	191	11414
Mar	11414	190	11604

Waiver Year 5

Unduplicated Number of Participants: 17379

Month	Base Number of Participants	Change	Participant Limit
Apr	11604	191	11795
May	11795	191	11986
Jun	11986	191	12177
Jul	12177	191	12368
Aug	12368	191	12559
Sep	12559	191	12750
Oct	12750	191	12941
Nov	12941	191	13132
Dec	13132	191	13323
Jan	13323	191	13514
Feb	13514	191	13705
Mar	13705	189	13894

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☐	☒	☒	☒	☒

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Apr	
Phase-in/Phase-out begins	Apr	2

	Month	Waiver Year
Phase-in/Phase-out ends	**Mar**	**5**

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

Infants and children under Age 19 (42 CFR 435.117 and 42 CFR 435.118);
Pregnant Women (42 CFR 435.116);
Mandatory Coverage of Parents and other Caretaker Relatives (42 CFR 435.110);
Optional Coverage of Parents and other Caretaker Relatives with Medicare (42 CFR 435.220);
Adult Group (coverage non-pregnant individuals age 19-64, not enrolled in Medicare) (42 CFR 435.119); Children who qualify for State adoption assistance (42 CFR 435.227);
Children for whom an adoption agreement is in effect or foster care maintenance payments are being made under Title IV-E, including Children with adoption assistance, foster care, or guardianship care under title IV-E, (42 CFR 435.145);
Individuals who qualify under 1902(a)(10)(A)(i)(II)(bb)(Qualified Severely Impaired); and
Disabled Adult Children (DAC) beneficiaries who are eligible under 1634c of the Social Security Act; Medically needy children under age 21 (42 CFR 435.308);
SSI-related medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting institutional LOC.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- (●) **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ( ) **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in**

the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

All LOC evaluations and reevaluations are completed by a NYS Health Home or the State's Independent Entity or the DDRO.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial evaluation of level of care for Children's waiver applicants is performed by a Care Manager in the State of New York in a Health Home or an Independent Evaluator employed by the State's Independent Entity (for Hospital or Nursing Facility LOC) or a Developmental Disabilities Regional Office staff person (for ICF/IID LOC).

In order to be a CANS-NY assessor (for NF and hospital LOC) for the Health Home, Independent Entity program or DDRO, a Health Home Care Manager (HHCM) or Independent Entity Independent Evaluator (IEIE) must attend a training (online or in-person) and complete a certification exam with a minimum reliability score of 0.70 (online).

In addition, an HHCM must have the experience required to meet the care planning needs of the child as determined by, but not limited to, acuity (as measured by the CANS-NY, and/or the children's overall needs), presence of a single qualifying or co-occurring conditions, including Serious Emotional Disturbance, Complex Trauma, co-occurring medical or co-morbid conditions. Staff qualifications for care managers that serve children with an acuity level of "high" as determined by the CANS-NY are:
• A Bachelors of Arts or Science with two years of relevant experience, or
• A License as a Registered Nurse with two years of relevant experience, or
• A Masters with one year of relevant experience.

For children with a high acuity that are enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply. Those qualifications are a minimum of one of the following educational or service coordination experience credentials:
i. two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
ii. one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
iii. one year of service coordination experience and an Associates degree in a health or human service field; or
iv. a Bachelors degree in a health or human service field. Demonstrated knowledge and understanding in the following areas:
i. infants and toddlers who may be eligible for early intervention services;
ii. State and federal laws and regulations pertaining to the Early Intervention Program;
iii. principles of family centered services;
iv. the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
v. other pertinent information.

An IEIE must be a graduate of an accredited nursing program who holds a current New York license as a registered nurse. The IEIE must also have at least two years of RN experience in home care.

In order to be an I/DD LOC assessor, the qualified professional with at least one year of experience in conducting assessments or developing plans of care for people with developmental disabilities. Initial LOCs are reviewed by a physician and include the assessments conducted by "qualified practitioners" who may administer and interpret standardized measures of intelligence and adaptive behavior. A qualified professional is a person with a directly relevant master's degree or doctoral level education in psychology, who has training and supervised experience in the use and interpretation of such measures consistent with the recommendations contained in the respective test manuals for measures and with the requirements of ERA/APA/NCME (1999) standards for test administration and use and interpretation of individual test results.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Certain Level of Care criteria are used to evaluate whether an applicant/participant requires and/or continues to require Children's waiver services. The applicant/participant must be under the age of 21; and require either a skilled nursing facility, ICF-IID or hospital level of care.

The UAS-NY is a secure system accessed through Health Commerce System (HCS) web portal. It contains the CANS-NY assessment HCBS eligibility algorithm used to determine functional criteria for NF and Hospital LOC, as well as eligibility information for the ICF/IID LOC determination.

The HHCM or IEIE has the responsibility for completion of initial Level of Care determinations and Annual Level of Care recertification's, as well as any periodic LOC recertifications. A subset of the assessment instrument, the CANS- NY is performed at least annually and as needed when significant changes occur in the child's life for the determination of NF and Hospital Level of Care (LOC). The Developmental Disability Regional Office (DDRO) will have UAS-NY eligibility access to complete the ICF/IID LOC for children requiring that LOC initially as well as for the annual redetermination. The DDRO will refer the child back to the HH or IE for the plan of care development.

The LOC determination for the Waiver is made based on the following: 1. the child meets the clinical eligibility criteria, 2. the Waiver candidate must be capable of being cared for in the community if provided access to appropriate waiver and state plan services. If the aforementioned criteria for the waiver are not met by applicant, the applicant's needs are managed through other services, including possible institutional placement in a hospital, nursing facility or ICF/IID.

CANS-NY HCBS eligibility algorithm is based on a subset of the CANS-NY questions or items and has been used for assessing individual improvement, identification of service needs, determination of NF and Hospital level of care, treatment planning, assessing the quality of services, and providing feedback regarding system functioning. CANS-NY also helps guide choices about treatment type, intensity and progress by the child to monitored continuous appropriateness of services based on the LOC determination.

The ICF/IID level of care instrument for the HCBS Waiver is identical to the level of care instrument used for ICF/DD. The same instrument is used for both initial evaluations and re-certifications. A paper copy of the level of care instrument has been submitted in the Comprehensive 1915(c) waiver and is available from OPWDD for CMS' review upon request. The level of care instrument and instructions are available on the OPWDD website at the following location: http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/home. The level of care instrument does not limit participation by individuals with certain conditions or diagnoses. Decisions about ICF/IID eligibility are also documented in the Health Commerce System (HCS).
The criteria appearing in the level of care instrument are:
1. Evidence of a developmental disability,
2. Disability manifested before age 22,
3. Evidence of a severe behavior problem (not required),
4. Health care need (not required),
5. Adaptive behavior deficit in one or more of the following areas: communication, learning, mobility, independent living or self-direction.

The applicant must have functional limitations that demonstrate a substantial handicap. For most applicants over the age of eight, the substantial handicap must be determined using a nationally normed and validated, comprehensive measure of adaptive behavior, administered by a qualified professional. For applicants over the age of eight who have an IQ of 60 or lower, the presence of a substantial handicap may be assessed and confirmed through clinical observation or interview rather than standardized testing.

For children (birth through eight) with a developmental delay, but no specific diagnosis, provisional eligibility may be confirmed based on clinical judgment by use of criteria based on 20 CFR, Appendix 1 to Subpart P of Part 404 regarding SSI eligibility, and determination of functional limitations in motor development, cognition and communication or social function. Consistent with Section 200.1 (mm)(1) of NYS Education Department regulations, substantial handicap associated with delay can be documented by the results of an evaluation that indicates:
- A 12-month delay in one or more functional areas, or
- A 33% delay in one functional area, or a 25% delay in each of two functional areas; or
- If appropriate, standardized instruments are administered yielding a score of 2.0 deviations below mean in one functional area or a score of 1.5 standard deviations below the mean in each of two functional areas.

Additional information on this ICF-IID process is contained within OPWDD policy guidance. Any future changes to this process/requirements will be contained within OPWDD policy guidance

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The CANS-NY eligibility algorithm for NF and hospital LOC based on a subset of the CANS-NY assessment or the ICF/IID tool will be used to determine level of care for initial and annual redeterminations. The ICF/IID LOC tool is the same as the instrument used to determine ICF/IID institutional care. The CANS-NY tool has been validated against the criteria used for admission to hospitals and nursing facilities by the CANS-NY Technical Assistance Institute at Chapin Hall and found to be reliable, valid and fully comparable. For more information see: https://www.chapinhall.org/project/CANS-NY-technical-assistance-institute/

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The information collected for eligibility, at a minimum, includes: family background, diagnosis, a complete description of the child's medical and behavioral health condition, type and frequency of needed medical/clinical interventions, developmental level of the child, and any other medical or social information pertinent to the child in order to determine and document the level of care at which the child is assessed.

If the HHCM or IEIE needs additional information to complete the eligibility evaluation, he/she may directly request the information from the parent, child if appropriate, or the child's physician. The Children's waiver will utilize the CANS-NY or ICF/IID to determine a potential waiver participant's initial level of care and his/her annual LOC re- evaluations. The assessment will be completed only by individuals who have successfully completed the training in the use of CANS-NY (or DDRO trained individuals in the ICF-IID tool) and only those individuals will be able to access the web based technology of the UAS-NY, which houses the CANS-NY and ICF-IID eligibility information.

The eligibility evaluation presents care options for the individual and identify persons who are nursing home, ICF/IID, or hospital level of care eligible. Assessors are required to use their professional judgment to determine the appropriate program options for the individual.

The web based eligibility evaluation will be made available to the HHCM, IEIE, and MCO (if applicable). If there appears to be any question regarding the applicant's nursing home or hospital level of care, the selected HHCM or IEIE will consult with the NYSDOH to resolve any identified issues. The DDRO will consult with OPWDD and NYSDOH regarding any ICF-IID questions.

As part of the POC review, the HHCM or IEIE reviews the Eligibility Evaluation to confirm that the applicant meets the LOC criteria for waiver participation; confirms Medicaid eligibility; reviews recent documentation to support a functional eligibility; and confirms the age of the applicant.

The HH or IE is responsible for assuring that the initial and annual LOC assessments are completed by qualified evaluators and in a manner timely to waiver participation. NYSDOH staff are able to access the UAS-NY through the Health Commerce System for review.

The Health Commerce System (HCS) is the NYS Department of Health's web portal. HCS is a secure, private network designed for sharing health-related information with health organizations throughout New York State. The HCS meets all of the requirements of HIPAA and HITECH, as well as other New York State laws. It contains the UAS-NY for LOC determinations as well as the MAPP-HHTS for Health Home outreach and enrollment.

Initial level of care evaluations must be completed prior to the approved enrollment date for community based individuals. Family of One eligible must have an initial level of care evaluation, plan of care and financial eligibility completed prior to enrollment in the HCBS waiver and Medicaid. Enrolled waiver participants are reevaluated annually in conjunction with the POC review or at any time the participant experiences a significant change of condition.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

In accordance with program guidelines, the HHCM or IEIE are required to assist the participant/family in understanding, meeting and completing necessary program requirements, such as the annual level of care re-evaluation.

Each HHCM/IEIE maintains an automated report which indicates when each participant's annual level of care re-evaluation is due. This is usually part of a larger re-evaluation package which may include Medicaid eligibility and medical documentation, physician orders and plan of care review. A change in the participant's medical condition or home situation could also necessitate a re-evaluation.

A HHCM, IEIE or DDRO staff member authorized to implement the eligibility evaluation, completes the eligibility evaluation on an annual basis or whenever there is a change in the enrollee's medical status. The re-evaluation documentation indicates the findings of the evaluation and is included in the UAS system.

As part of his or her role for oversight of children enrolled in the waiver, the HHCM or IEIE maintains regular contact with the MCO (for children enrolled in managed care) or NYSDOH staff (for FFS children) to discuss the progress of each enrollee, identify needs, and solve problems.

NYSDOH staff, the Interagency Monitoring Team, HHCM, IEIE, and the MCO review the reports at least quarterly to ensure that the annual level of care and other documentation that comprises the re-evaluation package was completed in a timely manner.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

HHCM or the IEIE must retain the letter of notification, level of care determinations, home assessments, plans of care and all other information pertaining to the child's enrollment and continued eligibility for the waiver in the waiver applicant's file. This information must be retained for the duration of the child's enrollment in the waiver and for at least six years after the child's 21st birthday for possible post-audit and evaluation by either state or federal agents.

A copy of the initial evaluation of the waiver applicant is kept on file in the UAS system.

The UAS-NY is a web-based application. All eligibility evaluation information is entered directly into and stored in the web-based application. The eligibility evaluation information is stored on a secure server for the CANS-NY eligibility algorithm. The DDRO maintains a copy of any information not contained in the UAS-NY system for ICF-IID determinations.

The HHCM, IEIE or DDRO is the primary person to arrange for the annual LOC reassessment by a certified assessor. The HH/IE is responsible to maintain a system for tracking the annual LOC re-assessment due date. Any printed LOC assessments must be stored in a secure locked location.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
An evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future. The percent of children that met LOC requirements prior to receiving 1915(c) services(Percentage – number of "Eligible Children" with an approved LOC present in the record prior to HCBS service receipt/All records reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC approvals

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Health Home or Independent Entity	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Health Home or Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC. The percent of Annual determinations where the level of care criteria were correctly applied. (percentage-number of records with LOC correctly applied/total records reviewed).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%CI
☒ **Other** Specify: Health Home or Independent Entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Health Home or Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC. The percent of initial LOC forms/instruments completed as required in the approved waiver. (Percentage-number of LOC forms present in the record/total records reviewed)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% CI
☒ **Other** Specify: Health Home or Independent Entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Health Home or Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

A statistically significant random sample of waiver cases (95% CI) are randomly selected for review by NYSDOH or its designee. The materials reviewed include the child's assessments, physician orders, case management plans, and claim detail reports. Documents are reviewed for proper signatures and dates, timely completion, follow-through on the medical plan and overall plan of care and utilization of services. Care management notes are also reviewed in order to substantiate billings and subsequent Medicaid reimbursement.

Tracking reports:
Quarterly reports from data entered by Health Homes/IE are used as a tracking tool to monitor program activity.

Conference calls:
Regular conference calls enable the sharing and peer discussion of HCBS issues between the State staff, MCOS, HH, and IE. NYSDOH staff may also present new directives or waiver topics.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH/IE or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including an issue with a Level of Care determination. During the annual case reviews, NYSDOH or its designee performs quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied, the LOC determinations and redeterminations are made timely, and the processes and forms outlined in the waiver were utilized correctly. In instances when it is discovered that this has not occurred the team recommends that the HHCM or IEIE take steps to initiate a new level of care determination. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

In such situations, the standard procedure is for NYSDOH staff, MCO, and Interagency Monitoring Team to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The HH or IE must provide a plan of correction. NYSDOH staff, MCO, and the IMT may collaboratively work with the HH or IE to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and the MCO.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM or IEIE will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

Unsatisfactory accessibility modification and adaptive and assistive equipment contractors will be notified of their disqualification from further service by the administering LDSS or MCO. The HHCM or IEIE will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO, IE staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO, IE and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of application for enrollment in the waiver, the HHCM/IEIE ensures that eligible individuals have been informed of feasible alternatives for care. Individuals who are 18 years of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice of enrollment in waiver and provider or to disenroll from the HH and enroll in the IE during the HCBS enrollment process and each annual reevaluation or at anytime the individual/family contacts the Health Home. The applicant, applicant's parents/ guardians/ legally authorized representative are required to sign the Freedom of Choice form indicating their decision whether or not to have their child receive services under the Medicaid waiver. This form must be witnessed and dated; it is kept as part of the applicant's permanent case file at the HH/IE.

The HHCM/IEIE also informs applicants/parents/legal guardians of the Health Homes available in area and the ability of the child to opt out of the Health Home and be served by the Independent Entity (or opt into the Health Home if they are currently served by the Independent Entity). The applicant/parents/legal guardians also sign the Choice of Case Management/Provider Selection form, indicating their choice of HH or IE and HCBS waiver providers for their child. Each HH/IE has a list of available waiver providers that is shared with the participants and their parent(s)/legal guardians including the HCBS providers available in each MCO. A copy of each of these forms is given to the parent, and maintained in HH/IE.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice form and Choice of Care Management/Provider Selection form are kept on file at the HH/IE in the applicants' case files.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Persons with limited fluency in the English language must be able to apply for benefits without undue hardship. The HH/IE must have arrangements to provide interpretation or translation services for a person who will need them. Non-English speaking applicants may bring a translator of their choice with them to the HH/IE. However, applicants cannot be required to bring their own translator, and no person can be denied access on the basis of HH/IE's inability to provide adequate translations. [NYS DOH GIS 99 MA/021 and 95 INF-15] All HH/IE are required to contract with telephone translation/interpretation services for applicants with limited English proficiency.

The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

Further, on October 6, 2011, NYS Governor Cuomo signed Executive Order (EO) # 26, "Statewide Language Access Policy" requiring State agencies, that provide direct public services, to offer free language access services to limited English proficient members of the public. Accordingly, statewide interpretation and translation contracts are in place to assist waiver applicants and participants.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Case Management**		
Statutory Service	**Community Habilitation**		
Statutory Service	**Day Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Other Service	**Adaptive and Assistive Equipment**		
Other Service	**Caregiver/Family Supports and Services**		
Other Service	**Community Self-Advocacy Training and Supports**		
Other Service	**Crisis Intervention**		
Other Service	**Environmental Modifications**		
Other Service	**Family Peer Support Services**		
Other Service	**Non-Medical Transportation**		
Other Service	**Palliative care - Expressive Therapy**		
Other Service	**Palliative care – Bereavement Service**		
Other Service	**Palliative care – Massage Therapy**		

Service Type	Service		
Other Service	Palliative care – Pain and Symptom Management		
Other Service	Vehicle Modifications		
Other Service	Youth Peer Support and Training		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Case management encompasses a wide range of activities the objectives and functions of which include: assisting children and families gain access to MA State Plan and other specified community based services; developing and implementing a plan of care that meets the needs of the participant; assuring that services are provided in a cost effective manner in accordance with the plan of care; and maximizing private health insurance for covered services. CAH I/II children may also receive services in the State's Early Intervention Program, however, CAH I/II Case management will not be reimbursed if the child is receiving duplicative case management through Early Intervention Services or Medicaid Service Coordination. The implementation of a Restriction Exception (R/E) code restricts any duplication of payment. The participant's parent/legal guardian must select a case manager before the waiver application is submitted to NYSDOH waiver management staff.

In accordance with federal and state regulations, the participant must be offered freedom of choice when choosing a MA provider at the time of application. The selected case management agency must meet the qualifications as outlined in NYS Regulations 18 NYCRR 505.16 and be enrolled as a CAH I/II case management provider. The availability of case management agencies varies throughout the State.

Agencies authorized to provide case management to a child are:
- Professional Case Management Agencies enrolled as a CAH I/II provider.

CAH I/II case managers must adhere to all Medicaid rules and regulations, and follow established program policy. Specifically, the case manager will:
- Assist children and their families to gain access to the full range of available community based services.
- Assure provided services match the particular needs of the participant and their family.
- Encourage active participation of the participant's family in the plan of care.
- Assure family and home health care providers have taken reasonable steps to maintain the child's health and safety in the community.
- Assure MA services are delivered in a cost effective manner and that alternate sources of reimbursement, such as private health insurance, are maximized.
- Assist with the development of the Plan of Care and its update, at a minimum annually, and securing necessary MD orders and assessments necessary to assure Plan of Care implementation.
- Maintain regular contact with the LDSS, CAH I/II coordinator the child and his/her parent/legal guardian. At a minimum, the case manager will maintain contact with the participant as required by the schedule of contacts based on the child’s health home acuity.

It is recommended that the case manager accompany the assessing nurse on visits to the child's home.

At a minimum, the case manager will maintain face-to-face contact with the child as required by the schedule of contacts based on the child’s health home acuity. It is recommended that the case manager accompany the assessing nurse on visits to the child’s home. CAH Case Managers are expected to meet face-to-face with all individuals on their caseloads as frequently as needed based upon each person’s individual needs and circumstances. However, there must be at least one face-to-face meeting provided each month. Face-to- face meetings and home visits are tools used by the CAH case manager to assess, identify and deliver the case management activities and interventions within the scope of CAH Case Management and the person’s plan of care. Face-to-face meetings should have a purpose and an outcome (e.g. observing for health and safety). This means that it is not appropriate for face-to-face meetings to be used purely for social or recreational purposes. At least one face to face meeting will occur in the child's home every six months.

Case Managers are not permitted to provide other direct waiver services to the participant.
Note: This service does not duplicate other services available through the New York Medicaid State Plan. In the case of Hospice/Palliative services the case manager provides linkage and referral for other services beyond the scope of Hospice/Palliative interdisciplinary team.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All case management is reimbursed using the existing 15 minute unit fee schedule expense reimbursement methodology.
NYSDOH will implement caseload size limits effective 10/1/17. This timeframe allows for notification of the change to provide appropriate training, support waiver participant choices, and allow for the CAH case management agencies sufficient time to hire and train new staff in order to come into compliance with this new service criteria. NYSDOH has established a maximum caseload size of no more than 30 individuals per case manager. This caseload limit is inclusive of any individual that the case manager renders case management services to, and is not limited to

those individuals receiving services under this waiver. This caseload size reflects the individual case manager's scope of responsibility and accounts for the level of support required by individuals receiving services under the CAH I/II waiver.

Case management services are limited to 120 hours annually, not to exceed 10 hours monthly, unless otherwise indicated in the participant's plan of care and authorized by the LDSS.

New Transition Plan and Options
Children will be given an option of two Case Management models with the following transition activities and oversight. The goal of the transition is to ensure continuity of care and the transition for children and families be as seamless as possible. The State's transition plan is designed to ensure that all children currently in receipt of 1915(c) services retain the access to services they need with no interruption due to the Children's Medicaid Transformation. In addition to MCO and State staff oversight, if a specific child is found to have difficulty maintaining his/her services during this transition, the family may contact their care manager, call the State's toll-free managed care help line at: 1-800-206-8125 or email: managedcarecomplaint@health.ny.gov
1. Health Home - Health Home is a care management model for individuals enrolled in Medicaid with chronic conditions, including complex medical and/or behavioral health needs. Health Home care managers are responsible for developing a person-centered, family and youth driven, comprehensive care plan that includes all the medical, behavioral health (mental health and substance use) and community and social supports and services the member needs. There are 16 Health Homes that have been designated to provide Health Home care management to children. Under the State's Transition Plan and in preparation for the April 1, 2019 implementation, between January 1, 2019 and March 31, 2019, all 1915(c) Transitioning Children will transition to Health Home Care Management, with the consent of the child/parent, guardian, or legally authorized representative. Transitioning children that have been working with a 1915(c) waiver care coordinator that has transitioned to Health Home will not need to change care managers. If consent to enroll in Health Home is obtained, then the Health Home care manager will develop a Health Home Comprehensive Plan of Care and arrange for HCBS to continue. The Health Home care manager may also begin preliminary care planning around the new services that will be made available April 1, 2019. During the Transition Process, a Health Home Comprehensive Plan of Care that includes HCBS will continue authorization of HCBS.

2. Independent Entity with additional monitoring by the Independent Entity in FFS and by the MCO if the child is in an MCO. - Members who opt out of Health Home care management will be referred to the State Independent Entity who will develop HCBS plan of care and arrange for HCBS. If the child is in FFS, the IE will maintain contact with the child and monitor service delivery. If the child is in MC, the MCO will monitor service delivery. Beginning February 1,2019, the Independent Entity will be available to accept referrals of 1915(c) Transitioning Children who are in receipt of HCBS and who opt out of Health Home enrollment. The Independent Entity will develop a person-centered plan of care for provision of HCBS and assist with transitioning HCBS services that will now be provided under the authority of the State Plan (See Attachment E.) For children who are enrolled in Medicaid managed care, the MMCP will monitor access to care and coordinate with the Independent Entity to maintain the HCBS plan of care. For children who are not enrolled in a Medicaid Managed Care Plan, the Independent Entity will work with the State to monitor access to care, including HCBS, delivered via Medicaid fee- for-service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Sunset 3/31/2019

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non Profit Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Non Profit Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

one year of case management experience and a degree in a health or human services field (provide a copy of diploma & copy of resume highlighting relevant experience);
b. one year of case management experience and an additional year of experience in other activities with the target population (provide a copy of resume highlighting relevant experience);
c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined in this application and above mentioned directives, including the performance of assessments and development of Service Plans (provide a copy of diploma & evidence of practicum with case management experience); or
d. meet the regulatory case management requirements of another State agency

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify the case management agency's qualifications.

Frequency of Verification:

Verification of the Case Management Agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Community Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Habilitation covers face-to-face services and supports related to the child's acquisition, maintenance and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and/or Health-Related Tasks delivered in the community (non-certified) settings.
Acquisition, maintenance and enhancement are defined as:

Acquisition is described as the service available to a child who is seeking greater independence by learning to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task.
Maintenance is described as the service available to prevent regression in the child's skill level and to also prevent loss of skills necessary to accomplish the identified task.
Enhancement activities are provided to the child through training and demonstration to promote growth and independence with an already acquired skill level and to support the child's goal outside of the training environment.

ADL, IADL, skill acquisition, maintenance and enhancement are face-to-face services that are determined by the person-centered planning process and must be identified in the child's plan of care (POC) on an individual or group basis. These identified services will be used as a means to maximize personal independence and integration in the community, preserve functioning and prevent the likelihood of future institutional placement. For this reason, skill acquisition, maintenance and enhancement services are appropriate for children who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

ADL, IADL skill acquisition, maintenance and enhancement is related to assistance with functional skills and may help a child who has difficulties with these types of skills accomplish tasks related to, but not limited to:

Self-care Life safety
Medication and health management Communication skills
Mobility
Community transportation skills Community integration Appropriate social behaviors Problem solving
Money management

Provider and Condition Requirements

ADL, IADL, skill acquisition, maintenance and enhancement will be performed by a direct care worker, who shall include personal care aides; personal attendants; certified home health aides; direct service professionals who meet the licensure and certification requirements under NYCRR Title 18; or providers approved through the Office for People With Developmental Disabilities (OPWDD) to provide Community Habilitation

ADL, IADL skill acquisition, maintenance and enhancement must be provided under the following conditions:

The need for skills training or maintenance activities has been assessed, determined and authorized as part of the person-centered planning process;

o Provider agencies of Community Habilitation must develop a Habilitation service plan to document the child's goal(s)/outcome(s), health and safety needs required during the delivery of the service, and the necessary staff actions to assist the child reach his/her Community Habilitation goal(s)/outcome(s), and health/safety needs.
The activities are for the sole benefit of the child and are only provided to the child receiving home and community-based services or to the family/caregiver in support of the child;
The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child has a progressive medical condition.
The activities provided are consistent with the child's stated preferences and outcomes in the plan of care (POC);
The activities provided are coordinated with the performance of ADLs, IADLs and health related tasks;
Training for skill acquisition, maintenance and enhancement activities that involve the management of behaviors must use positive enforcement techniques; and
The provider is authorized to perform these services for HCBS recipients and has met any required training, certification and/or licensure requirements.

Some specific ADL services available for training includes, but is not limited to: Bathing/personal hygiene; dressing; eating; mobility (ambulation and transferring); and toileting.

Some specific IADL services available for skills training includes, but is not limited to:
Managing finances; assisting with transportation (as indicated in the POC); shopping for food, clothes and other essentials; preparing meals; assisting with the use of the telephone and/or other communication devices; managing medications; light housekeeping; environmental maintenance such as maintaining safe egress; and laundry.
If the POC indicates that learning how to navigate travel from one location in the community to another is a goal for the child, this service will include the assistance provided by a direct care worker to accompany the child while learning the skill. The face-to-face service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

Health-related tasks are defined as specific tasks related to the needs of a child, which can be delegated or assigned by licensed health-care professionals under State law to be performed by a certified home health aide or a direct service professional. Health related tasks also include tasks that home health aides or a direct service professional can perform under applicable exemptions from the Nurse Practice Act.

Some specific health-related tasks available for assistance includes, but is not limited to:
Performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering and recording medications; assisting with the use of medical equipment, supplies and devices; assisting with special skin care; assisting with a dressing change; and assisting with ostomy care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
These services can be delivered at any non-certified, community setting. Such a setting might include the child's home which may be owned or rented, and work setting. Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children's HCBS. Approved settings do not include an OPWDD certified residence, congregate or institutional settings, a social day care or health care setting in which employees of the particular setting care for or oversee the child. Foster care children meeting LOC may receive these services in a home or community based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services law section 427.2(f) as a facility established for the 24 hour care and maintenance of 13 or more children and operated by a child care agency (Voluntary Foster Care Agency).

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under this HCBS Waiver. Children living in certified settings may only receive this service on week days with a start time prior to 3 pm. For school-age children, this service cannot be provided during the school day when a child is participating or enrolled in a school program.

Time spent receiving another Medicaid service cannot be counted toward the Habilitation billable service time. This service cannot be delivered nor billed while a child is in an ineligible setting, such as in a hospital, ICF/IID or skilled nursing facility.

Community Habilitation services provided under this waiver cannot be duplicative or delivered at the same time as services otherwise available to a child through a local educational agency including those services available under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973.

Some specific IADL services available for skills training includes, but is not limited to:
Managing finances; assisting with transportation (as indicated in the POC); shopping for food, clothes and other essentials; preparing meals; assisting with the use of the telephone and/or other communication devices; managing medications; light housekeeping; environmental maintenance such as maintaining safe egress; and laundry.
If the POC indicates that learning how to navigate travel from one location in the community to another is a goal for the child, this service will include the assistance provided by a direct care worker to accompany the child while learning the skill. The face-to-face service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

Health-related tasks are defined as specific tasks related to the needs of a child, which can be delegated or assigned by licensed health-care professionals under State law to be performed by a certified home health aide or a direct service professional. Health related tasks also include tasks that home health aides or a direct service professional can perform under applicable exemptions from the Nurse Practice Act.

Some specific health-related tasks available for assistance includes, but is not limited to:
Performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering and recording medications; assisting with the use of medical equipment, supplies and devices; assisting with special skin care; assisting with a dressing change; and assisting with ostomy care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
These services can be delivered at any non-certified, community setting. Such a setting might include the child's home which may be owned or rented, and work setting. Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children's HCBS. Approved settings do not include an OPWDD certified residence, congregate or institutional settings, a social day care or health care setting in which employees of the particular setting care for or oversee the child. Foster care children meeting LOC may receive these services in a home or community based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services law section 427.2(f) as a facility established for the 24 hour care and maintenance of 13 or more children and operated by a child care agency (Voluntary Foster Care Agency).

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under this HCBS Waiver. Children living in certified settings may only receive this service on week days with a start time prior to 3 pm. For school-age children, this service cannot be provided during the school day when a child is participating or enrolled in a school program.

Time spent receiving another Medicaid service cannot be counted toward the Habilitation billable service time. This service cannot be delivered nor billed while a child is in an ineligible setting, such as in a hospital, ICF/IID or skilled nursing facility.

Community Habilitation services provided under this waiver cannot be duplicative or delivered at the same time as services otherwise available to a child through a local educational agency including those services available under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Habiliation Agency providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Habilitation

Provider Category:

Agency

Provider Type:

Community Habiliation Agency providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Certified by the Office for People with Developmental Disabilities (OPWDD) to provide community habilitation.
Providers must have appropriate license, certification and/or approval in accordance with State requirements. Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks.
OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice. Day Habilitation (DH) services are provided to a child at a NYS certified (e.g., OPWDD certified) setting typically between the daytime hours of 9am-3pm. However, service delivery may include outings to community (non-certified) settings.

Individual Day Habilitation (a one-to-one, individual-to-worker provided service with an hourly unit of service) and Group Day Habilitation services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or less frequently as specified in the participant's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

A supplemental version of Individual and Group Day Habilitation is available for children who do not reside in a certified setting. The supplemental Day Habilitation is provided outside the 9am-3pm weekday time period, and includes later afternoon, evenings, and weekends. Day Habilitation and Supplemental Day Habilitation services cannot be delivered at the same time.

All Day Habilitation services (Group and individual) have the same service description and focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors or lessons taught in other settings. Provider agencies of Day Habilitation must develop a Habilitation service plan to document the child’s goal(s)/outcome(s), health and safety needs required during the delivery of the service, and the necessary staff actions to assist the child reach his/her Day Habilitation goal(s)/outcome(s), and health/safety needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Group and individual DH cannot be billed as overlapping services. Supplemental DH services, are those services provided on weekends and/or on weekdays with a service start time after 3:00 pm. Supplemental DH services are not available to individuals residing in certified residential settings with paid, professional staff, because the residence is paid for staffing on weekday evenings and anytime on weekends. Day Habilitation is limited to 6 hours a day

Any child receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child must have a developmental delay justifying the need for the provision of Day Habilitation, but the child must meet NF, ICF/IID or Hospital LOC.

Children have a maximum daily amount of services that are available to individuals based upon their residence. Individuals residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 pm on weekdays.

Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-profit organization
Agency	OPWDD Regional Office

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Non-profit organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Non-profit organizations include: nonprofit corporations formed under New York State Law or authorized to do business in New York, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities. If the provider agency employs professional clinical staff, that staff person must have the appropriate credentials stipulated by the OPWDD and/or the NYS Department of Education under the following regulations and laws:

• Nursing (8 NYCRR Part 64, and Education Law Title 8, Article 139)
• Speech Language Pathologist (8 NYCRR Part 75, and Education Law Title 8, Article 159)
• Psychology (8 NYCRR Part 72, and Education Law Title 8, Article 153)
• Social Work (8 NYCRR Part 74, and Education Law Title 8, Article 154)
• Rehab Counselor (14 NYCRR Part 679.99)
• Dietetics/Nutrition (8 NYCRR Part 79, and Education Law Title 8, Article 157)
• Occupational Therapy (8 NYCRR Part 76, and Education Law Title 8, Article 156)
• Physical Therapy (8 NYCRR part 77, and Education Law Title 8, Article 136)
• Applied Behavioral Sciences Specialist (8 NYCRR Part 79, and Education Law Title 8, Article 167).
• Behavioral Intervention Specialist (14 NYCRR part 633-16.b(32)

Certified by the Office for People with Developmental Disabilities (OPWDD) to provide day habilitation.
Providers must have appropriate license, certification and/or approval in accordance with State requirements. Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General.

Practitioners must operate in agencies which have been designated through the NYS Children’s Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

OPWDD Regional Offices may directly provide Day Habilitation HCBS waiver services through its regional offices.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General. Training must include:

• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

OPWDD Regional Office

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OPWDD Regional Offices may directly provide Day Habilitation HCBS waiver services through its regional offices.

Direct support professionals must have completed the training stipulated in 14 NYCRR Part 633.8 and the Direct Support Professionals Core Competencies curriculum. Direct service workers must have background checks. OPWDD directs provider agencies to screen staff against the Medicaid Excluded Provider lists maintained by the Department of Health and the HHS Office of the Inspector General. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's plan of care and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to:
• ability to communicate effectively with supervisors, co-workers and customers;
• generally accepted community workplace conduct and dress;
• ability to follow directions;
• ability to attend to and complete tasks;
• punctuality and attendance;
• appropriate behaviors in and outside the workplace;
• workplace problem solving skills and strategies;
• mobility training;
• career planning;
• proper use of job-related equipment and general workplace safety.

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.
• Resume writing, interview techniques, role play and job application completion.
• Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements
• Assisting in identifying community service opportunities that could lead to paid employment
• Helping the youth to connect their educational plans to future career/vocational goals
• Helping youth to complete college, technical school or other applications to continue formal education/training
• Helping youth to apply for financial aid or scholarship opportunities

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
This service may be delivered in a one-to-one session or in a group setting of two or three participants. Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Prevocational services will not be provided to an HCBS participant if:
(i) Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR).
(iii) Vocational services that are provided in facility based work settings that are not integrated settings in the general community workforce.

Prevocational services are limited to 2 hours a day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:

Prevocational Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual.
• Provider agencies adhere to state cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Individual Qualifications:
• Minimum qualifications of an Associate's degree with one year human service experience. Direct service workers must have background checks.
• Preferred qualifications of a Bachelor's degree with one year experience in human services working with children/youth

Required Training
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification of a Bachelor's degree with three years experience in human services. Preferred qualification of a Master's with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service focuses on short-term assistance provided to children/youth regardless of disability (developmental, physical and/or behavioral) because of the absence of or need for relief of the child or the child's family caregiver. Such services can be provided in a planned mode or delivered in a crisis situation. Respite workers supervise the child/youth and engage the child/youth in activities that support his/her and/ or primary caregiver/family's constructive interests and abilities.

Respite providers offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers will regularly communicate the details of the child/youth's intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

Planned
Planned respite services provide planned short-term relief for the child or family/primary caregivers that are needed to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health and/or health care needs. The service is direct care for the child/youth by individuals trained to support the child/youth's needs. This may occur in short-term increments of time (usually during the day) or on an overnight or longer-term increment. Planned Respite activities support the plan of care goals and include providing supervision and activities that match the child/youth's developmental stage and continue to maintain the child/youth health and safety.

Crisis
Crisis Respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be used when challenging behavioral or situational crises occur which the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used as a result of crisis intervention or from visiting the emergency room. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan or risk mitigation strategy.

Crisis Respite services may be delivered in a home or residence by qualified practitioners, out of home/residence by staff in community-based sites, or in allowable facilities. Services offered may include: site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Ongoing communication between child/youth or the family/primary caregiver receiving crisis respite for their child, the crisis respite staff, and the child/youth's established behavioral health and health care providers is required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs.

At the conclusion of a Crisis Respite period, crisis respite staff, together with the child/youth and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the child's plan of care. Children are encouraged to receive Crisis Respite in the most integrated and cost-effective settings appropriate to meet their respite needs. Out of home Crisis Respite is not intended as a substitute for permanent housing arrangements.

Planned Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.
Planned Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.
Crisis Day Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.
Crisis Overnight Respite: This service may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe and as indicated in the child's POC overseen by the respite provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Planned/Crisis Day respite services can be provided in the home of an eligible youth or a community setting. Planned/Crisis Overnight settings include those licensed or certified by OCFS, OMH, or OPWDD and designated to provide respite services: Foster boarding home, OCFS licensed/certified setting, Teaching Family Home, OMH certified Community Residence: (community-based or state operated), including Crisis Residence. Please note there is an exemption in the CMS HCBS Final Rule (March 16, 2014) for allowable respite care settings; OR
o An OMH licensed Community Residence (community-based or state-operated), including Crisis Residence or Teaching Family Home, which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594; OR
o OCFS Licensed agency boarding home, a group home, a group residence, or an institution and certified foster boarding homes
o OPWDD certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD.

Note: Services to children and youth in foster care must comply with Part 435 of 18 NYCRR Respite is not an allowable substitute for permanent housing arrangements. For respite services that may be provided as crisis or overnight, Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
Please note: It is the responsibility of the provider upon referral to ensure that respite providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology), OR have made arrangements for an appropriately trained and knowledge individual to address the individual child/youth's needs (including but not limited to physical and/ or medical needs such as medications or technology. Examples include arrangement of approved Private Duty Nurse for a technology dependent child while in a respite setting.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OMH-certified Community Residence: (community-based or state operated) including Crisis Residence
Agency	Foster boarding home
Agency	Provider Agency
Agency	OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution
Agency	OPWDD certified residential setting

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

OMH-certified Community Residence: (community-based or state operated) including Crisis Residence

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OMH certification

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Facilities must have an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594.
Respite workers must be staff of the certified program. Direct service workers must have background checks.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety And Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
Minimum qualification is a Bachelor's degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Foster boarding home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements:
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Respite providers must be a Licensed Foster Parent pursuant to Part 435 of 18 NYCRR Direct service workers must have background checks.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety And Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
Minimum qualification is a Bachelor's degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provision of service in child's residence or other community-based setting (e.g. park, shopping center, etc.):
Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements:
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

Individual Staff Qualifications:
o Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the Care Coordinator to ensure that providers have adequate training and knowledge to address the individual child's needs (including but not limited to physical and/ or medical needs such as medications or technology), has experience working with children/youth (preference given to those with experience working with children/youth with special needs);
A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
o Direct service workers must have background checks.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety And Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification is a Bachelor's degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.

Direct service workers must have background checks. Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety And Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
Minimum qualification is a Bachelor’s degree with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

OPWDD certified residential setting

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OPWDD certification

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Facility where the individual does not permanently reside (i.e., Community-based or state-operated OPWDD-certified setting, Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD. Direct service workers must have background checks.

Respite workers must be staff of the certified program.

Practitioner Training Qualifications:
• Mandated Reporter
• Personal Safety And Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
In an OPWDD-certified setting, supervisors in the provision of Respite in the Children's Waiver must have over 3 years' experience in the certified setting and such provision is under the oversight of a licensed professional, Qualified Intellectual Disabilities Professional (QIDP), or master's level professional in a Behavioral Health field.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting.

Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Supported employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.
In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.

Supported employment services may be provided in a variety of settings, particularly work sites. Supported employment services include the following:
• Supervision and training that are not job-related
• Intensive ongoing support
• Transportation to and from the job site
• Interface with employers regarding the individual's disability(ies) and needs related to his or her healthcare issue(s)
• Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment necessary for employment)
• Job finding and development training in work behaviors
• assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
• On-site support for the individual as they learn specific job tasks
• Monitoring through on-site observation through communication with job supervisors and employers. Supported employment is provided through individual face-to-face intervention.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.
Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

Supported Employment service will not be provided to an HCBS participant if:
(i) Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.
(iii) Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
(iv) Supported employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
(v) Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
• Payments that are passed through to users of supported employment services.

Supported employment is limited to 3 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Individual Qualifications:
• Minimum qualifications of an Associate's degree with one year human service experience. Direct service workers must have background checks.
• Preferred qualifications of a Bachelor's degree with one year experience in human services working with children/youth
• Training: Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Supervisor Qualifications:
• Minimum qualification of a Bachelor's degree with three years of experience in human services.
• Preferred qualification of a Master's with one year experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive and Assistive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides technological aids and devices identified within the child's Plan of Care (POC) which enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child.

Adaptive and Assistive Equipment includes but not limited to:
Direct selection communicators, Alphanumeric communicators, Scanning communicators, Encoding communicators, Speech amplifiers, Electronic speech aids/devices, Voice activated, light activated, motion activated and electronic devices, Standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the participant's strength, mobility or flexibility to perform activities of daily living, Adaptive switches/devices, Meal preparation and eating aids/devices/appliances, Specially adapted locks, Motorized wheelchairs, Guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4). Electronic, wireless, solar-powered or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the participant to live, work or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices may include computers, observation cameras, sensors, telecommunication screens and/or telephones and/or other, telecare support services/systems that enable the participant to interact with remote staff to ensure health and safety. Such devices cannot be used for the purpose of surveillance, but to support the person to live with greater independence, Devices to assist with medication administration, including tele-care devices that prompt, teach or otherwise assist the participant, Portable generators necessary to support equipment or devices needed for the health or safety of the person, and stretcher stations.

Adaptive and Assistive Equipment Services include:
A. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
B. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participants;
C. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
D. training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and
E. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The adaptive and assistive equipment available through the HCBS authorities including CFCO cannot duplicate equipment otherwise available through the Medicaid State Plan at 1905(a) of the Social Security Act or other federal/state funding streams. Equipment must be beyond the scope of Durable Medical Equipment (DME). Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

Adaptive Devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity and approved by the State or its designee. Ongoing monitoring associated with telecare support services or other approved systems authorized under this definition may be provided if necessary for health and safety and documented to the satisfaction of the State or designee. The HHCM, IEIE or MCO CM will ensure, that where appropriate, justification from physicians, or other specialists or clinicians has been obtained.

Warranties, repairs or maintenance on assistive technology only when most cost effective and efficient means to meet the need, and are not available through the Medicaid state plan at 1905(a), CFCO or third-party resources.

Cost Limits
AT costs cannot exceed $15,000 per year without prior approval from the Governmental Entity in conjunction with NYSDOH approval if exceeding established limits or the MCO.
The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

For Adaptive and Assistive Equipment, the Governmental Entity (for FFS enrollees) or MCO (for managed care enrollees) is the provider of record for billing purposes using the standard bidding process. Services are only billed to Medicaid once the equipment is procured and the amount billed is equal to the purchased value.

The Governmental Entity or MCO secures a local vendor qualified to complete the required work. Activities include and are not limited to determining the need for the service, the safety of the proposed equipment, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that vendors are qualified and that State required bidding procedures have been followed. Services are only billed to Medicaid or the MCO once the equipment is verified as received and the amount billed is equal to the contract value.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adaptive and Assistive Equipment Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive and Assistive Equipment

Provider Category:
Agency

Provider Type:

Adaptive and Assistive Equipment Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Governmental Entity or MCO staff verify the qualifications of Adaptive and Assistive Equipment vendor:
a. Must be familiar with the Adaptive and Assistive Equipment policies permitted in the waiver program as described in the program manual; the Governmental Entity or MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
b. Must be able to communicate well with all parties involved with the purchase of the equipment and any training needed, e.g. consumers, contractors, and local government officials.
c. Must be able to clearly describe in writing, and by design, the proposed purchase.
d. Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Governmental Entity (LDSS/DDRO)or MCO

Frequency of Verification:

Provider qualifications are verified at the beginning of the purchase by the Governmental Entity or MCO.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Caregiver/Family Supports and Services

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Caregiver/Family Supports and Services (formerly CAH Family Palliative Care Education (Training) enhance the child/youth's ability regardless of disability (developmental, physical and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community. Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.
Note: this service is not the State Plan service of Family Peer Support Services which is required to be delivered by a certified/credentialed Family Peer with lived experience.

Based upon the Caregiver/Family Supports and Services plan developed by the child/youth and caregiver/family team, this service provides opportunities to:
• Interact and engage with family/caregivers and children/youth to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities;
• Maintain and encourage the caregivers'/families' self-sufficiency in caring for the child/youth in the home and community;
• Address needs and issues of relevance to the caregiver/family unit as the child/youth is supported in the home and community; and
• Educate and train the caregiver/family unit on resource availability so that they might better support and advocate for the needs of the child and appropriately access needed services
• Direct instruction and guidance in the principles of children's chronic condition or life threatening illness. This service may be provided individually or in a group face-to-face intervention (no more than three HCBS eligible children/families)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.
• This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
• Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA)
Caregiver Family Supports and Services are limited to 3 hours per day.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Family Supports and Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines

• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Individual Staff Qualifications:
• Minimum qualification of a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS) with related human service experience. Direct service workers must have background checks.
• Preferred experience working with children/youth.

Training:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions Trauma Informed Care
Supervisor Qualifications:
• Minimum qualification of a Bachelor's degree with one year experience in human services working with children/youth.
• Preferred two years' experience in human services working with children/youth

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Self-Advocacy Training and Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Self-Advocacy Training and Support provides children/youth, family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. Community Self-Advocacy Training and Support is intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).

The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The Plan of Care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors. Community Self-Advocacy Training and Support improves the child/youth's ability to gain from the community experience, and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.

• Training (one-on-one or group) for the child/youth and/or the family/caregiver regarding methods and behaviors to enable success in the community. Each group must not exceed 12 participants (enrollees and collaterals).
• Direct self-advocacy training in the community with collateral contacts regarding the child/youth's disability(ies) and needs related to his or her health care issues.
• Self-advocacy training for the child/youth and/or family/caregiver, including during community transitions. This service is provided individually or in a group face-to-face intervention (No more than three HCBS eligible children/youth enrolled may attend a group activity at the same time)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (see Appendix F) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.
• This service may be provided in group settings but to no more than 12 participants (enrollees and collaterals). No more than three children may attend a group activity at the same time.
• This service cannot be delivered nor billed while an enrolled child is in an in-eligible setting, including hospitalization.
• This service cannot include special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA)
Community Self-Advocacy Training and Supports are limited to 3 hours a day

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Self-Advocacy Training and Supports

Provider Category:
Agency
Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team.
• Provider agencies and practitioners adhere to all Medicaid requirements.
• Provider agencies adhere to cultural competency guidelines
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
Individual Staff Qualifications:
• Preferred Qualifications: An individual employed by the agency with a Master's degree in education, or a Master's degree in a human services field plus one year of applicable experience. Direct service workers must have background checks.
• Minimum Qualifications: An individual employed by the agency with a bachelor's degree plus two years of related experience
• Training
o Mandated Reporter
o Personal Safety/ Safety In The Community
o Strength Based Approaches
o Suicide prevention training
o Domestic Violence Signs and Basic Interventions
o Trauma Informed Care

Supervisor Qualifications:
• Minimum qualifications of a Master's degree with one year experience in human services working

with children/youth.
• Preferred two years of experience in human services working with children/youth.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Crisis Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Please note that this waiver service was terminated as of March 15th,2020. It is now available to children via the State Plan under EPSDT SPA 20-0001.
Crisis Intervention (CI) Services are provided to children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it. The determination of the potential crisis is defined by the behavioral health professional. A behavioral health professional will do an assessment of risk and mental status, in order to determine whether or not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically sensitive and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. CI is a face-to-face intervention and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically sensitive, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate. Service is available with 24/7 availability and capacity to respond within one hour of call.
-Assessment of risk and mental status and the need for further evaluation and/or other health/behavioral health services.
-Development of a safety plan, which addresses the immediate circumstances and the prevention of future crises, and signing of appropriate releases
-Crisis resolution and debriefing with the identified Medicaid eligible child, the child’s family/caregiver and treatment provider
-Crisis resolution and debriefing with the child’s family/caregiver and the treatment provider.
-Care coordination includes:
1) Consultation with a physician or other licensed practitioner of the healing arts to assist with the child’s specific crisis and planning for future service access.
2.) It is the expectation that there will be documented follow-up.
3.) Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan. The entity that the child is referred to conducts an evaluation/assessment for additional longer term services.
-Crisis resolution with the identified Medicaid eligible child, the child’s family/caregiver and the treatment provider

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

AAll activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate. Service is available with 24/7 availability and capacity to respond within one hour of call.
-Assessment of risk and mental status and the need for further evaluation and/or other health/behavioral health services.
-Development of a safety plan, which addresses the immediate circumstances and the prevention of future crises, and signing of appropriate releases
-Crisis resolution and debriefing with the identified Medicaid eligible child, the child’s family/caregiver and treatment provider
-Crisis resolution and debriefing with the child’s family/caregiver and the treatment provider.
-Care coordination includes:
1) Consultation with a physician or other licensed practitioner of the healing arts to assist with the child’s specific crisis and planning for future service access.
2.) It is the expectation that there will be documented follow-up.
3.) Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan. The entity that the child is referred to conducts an evaluation/assessment for additional longer term services.
-Crisis resolution with the identified Medicaid eligible child, the child’s family/caregiver and the treatment provider

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-Profit Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Non-Profit Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Services should be provided by a culturally competent, trauma-informed, and linguistically responsive multidisciplinary team (of at least two professionals unless noted below), for programmatic or safety purposes. One member of a two-person crisis intervention team must be a behavioral health professional and have experience with crisis intervention service delivery. If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed practitioner must be available via phone. A peer support specialist may not respond alone. Behavioral health professionals are practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. For Crisis Intervention, these behavioral health professionals include: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background treatment mental health and/or substance use disorders OR one practitioner from the above list and one practitioner from the following who is not considered a behavioral health professional: Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

If one member of the crisis intervention team is a Peer support specialist, the Peer support provider must have a credential/certification as either:
1) An OMH established Family Peer Advocate credential, or
2) An OASAS established Certified Recovery Peer Advocate - Family.

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:
•Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child (ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
•Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
•Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates training or approved comparable training.
•Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
•Documented 1000 hours of experience providing Family Peer Support services.
•Agreed to practice according to the Family Peer Advocate Code of Ethics.
•Completed 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential and complete all other requirements of the professional family peer advocate credential that will allow services they provide to be billed if the applicant has:
•Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
An FPA may obtain a provisional credential if the applicant has (Continued)
•Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
•Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
•Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

An FPA with a provisional credential must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA OR Family Peer

Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

To be certified as CRPA-Family, the individual must be at least 18 years of age and have the following:
•Have 'lived experience' as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
•Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
•Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, medication assisted treatment and ethical responsibility.
•Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor's degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or completed the 30-Hour Recovery Coach Academy training.
•Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
•Passed the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
•Submitted two letters of recommendation.
•Demonstrated a minimum of 16 hours in the area of Family Support.
•Completed 20 hours of continuing education earned every two years, including six hours of Ethics.
Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient's treatment/recovery plan
Crisis Intervention Team Training: All members of the Crisis Intervention team are required to have training in first aid, CPR, Mandated Reporting, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SAFETALK), and crisis plan development.
Supervisor Qualifications: The supervisor is a competent mental health professional and must provide regularly scheduled supervision for all team members including peers. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. The supervisor must practice within the State health practice laws and ensure that providers are supervised as required under state law. For example, if a psychiatric nurse practitioner is on the team with fewer than 3,600 hours of experience, a psychiatrist must be on the team and supervise him/her. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.
Provider Agency Qualifications: CI practitioners must work within agencies that possess a current license to provide crisis and/or crisis treatment services or any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide comparable and appropriate crisis services referenced in the definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify the agency's qualifications.

Frequency of Verification:

Verification of the Agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Under this benefit, Environmental Modifications are permitted (formerly called Home and Vehicle Modifications)
Environmental Modifications
This service provides internal and external physical adaptations to the home or other eligible residences of the enrolled child which per the child's plan of care (POC) are identified as necessary to support the health, welfare and safety of the child or that enable the child to function with greater independence in the home and without which the child would require institutional and/or more restrictive living setting.

Service Components Environmental Modifications
Modifications include but not limited to: installation of ramps, hand rails and grab-bars, widening of doorways(but not hallways), modifications of bathroom facilities, installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient, lifts and related equipment, elevators when no feasible alternative is available, automatic or manual door openers/bells, modifications of the kitchen necessary for the participant to function more independently in his home, medically necessary air conditioning, Braille identification systems, tactile orientation systems, bed shaker alarm devices, strobe light smoke detection and alarm devices, small area drive-way paving for wheel-chair entrance/egress from van to home, safe environment modifications for behaviorally challenged participants require the prior review of a behavioral specialist and include window protections, reinforcement of walls, durable wall finishes, open-door signal devices, fencing, video monitoring systems and shatter-proof shower doors; and future technology devices that allow the participant to live more safely and independently to avoid possible institutional placement or placement in a more restrictive living environment, which are available at a reasonable cost in comparison to living in a more restrictive residential setting. The scope of environmental modifications will also include necessary assessments to determine the types of modifications needed.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the Governmental Entity in conjunction with NYSDOH if exceeding established limits or MCO.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Modifications
Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the child. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub.
Repair & Replacement of Modification: In most instances, a specific type of Environmental Modification is a one-time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a person moves to another home; if the current modifications are in need of repair, worn-out or unsafe; or if a participant wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods.

State policy places certain limitations on environmental modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Accessibility Modification Limits
Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan, Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams will be reimbursable under the HCBS Waiver.

Contracts for Home modifications may not exceed $15,000 per year without prior approval from the Governmental Entity in conjunction with NYS DOH or the MCO. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.
Provider Specifications

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Modification Contractor/Craftsman

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Environmental Modification Contractor/Craftsman

Provider Qualifications

License *(specify):*

Licensure appropriate to the trade

Certificate *(specify):*

Other Standard *(specify):*

Governmental Entity or MCO staff verify the qualifications of home modification providers present the following knowledge and skills:
a. Must be familiar with the home adaptation policies permitted in the waiver program as described in state guidance; the Governmental Entity/HRA/MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
b. Must be able to communicate well with all parties involved with the development of home adaptations, e.g. consumers, contractors, and local government officials.
c. Must be able to clearly describe in writing, and by design, the proposed home adaptation.
d. Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as applicable to the home modification)
e. Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
f. Must have skill in design/drafting in order to clearly describe the proposed modification.
g. Must be able to complete all components of an On-Site Evaluation as in Section (x) of this manual.

Contractors performing any adaptation for a child in the waiver program is required to:
a. Be bonded;
b. Maintain adequate and appropriate licensure;
c. Obtain any and all permits required by state and local municipality codes for the modification; and
d. Agree that before final payment is made the contractor must show that the local municipal branch of government that issued the initial permit has inspected the work.

Verification of Provider Qualifications

Entity Responsible for Verification:

Governmental Entity or MCO

Frequency of Verification:

Provider qualifications are verified at the beginning of the home modification contract by the Governmental Entity or MCO

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Peer Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10050 peer specialist

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Please note that this waiver service was terminated as of 08/01/2019. It is now available to via the State Plan under EPSDT SPA 19-0003.

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's plan of care. FPSS is a face-to-face intervention, a group face-to-face intervention. A group is a composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals. The Service is directed to the child, and includes contacts necessary for treatment with the family/caregiver or other collateral supports. FPSS can be provided through individual and group face-to-face work and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Components of FPSS include:
- Engagement, Bridging and Transition Support: Provide a bridge between families and service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
- Self-Advocacy, Self-Efficacy and Empowerment: Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
- Parent Skill Development: Support the efforts of families in caring for and strengthening their children's mental, and physical health, development and well-being.
- Community Connections and Natural Supports: Enhance the quality of life by supporting the integration of families into their own communities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The provider agency will assess the child prior to developing a plan of care for the child. Authorization of the plan of care is required by the DOH or its designee. Treatment services must be part of a plan of care including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. A group is composed may not exceed more than 12 individuals total. Medicaid family support programs will not reimburse for the following:
- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA's, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized plan of care.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's plan of care.
- Any intervention or contact not documented or consistent with the approved plan of care goals, objectives, and approved services will not be reimbursed.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non Profit Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Peer Support Services

Provider Category:
Agency
Provider Type:

Non Profit Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA); FPA with a provisional credential; or a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.
- FPA Credential- To be eligible for the FPA Credential, the individual must:
- Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
- Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates approved comparable training.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
- Documented 1000 hours of experience providing Family Peer Support services.
- Agreed to practice according to the Family Peer Advocate Code of Ethics.
- Completed 20 hours of continuing education and renew their FPA certification every two years.
- A provisional FPA credential:
- Demonstrated 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
- Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA). The provisional FPA must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA.
- Agreed to practice according to the Family Peer Advocate Code of Ethics.

Certified Recovery Peer Advocate (CRPA) with a Family Specialty:
To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:
- Have 'lived experience' as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: Have a Bachelor's Degree; Are certified by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or Completed the 30-Hour Recovery Coach Academy training.
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of Ethics.

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient's treatment/recovery plan.

Supervisor Qualifications: FPAs will be supervised by:
1) Individuals who have a minimum of 4 years' experience providing FPSS services, at least 1 year of

which is as a credentialed FPA with access to clinical consultation as needed. The clinical consultation may be provided by a staff member or through a contract OR
2) A “qualified mental health staff person” with a) training in FPSS and the role of FPAs b) efforts are made as the FPSS service gains maturity in NYS to transition to supervision by experienced credentialed FPA within the organization OR
3) From a competent behavioral health professional meeting the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 OR
4) A Certified Alcohol and Substance Abuse Counselor (CASAC) working within an OASAS certified program.
The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that 1 hour of supervision be delivered for every 40 hours of Family Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist’s timesheet and is the primary contact on other related human resource management issues.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify the agency's qualifications.

Frequency of Verification:

Verification of the Agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's Plan of Care.

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Examples where this service may be requested include transportation to: HCBS that an individual was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, community integration activity, etc. This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant's plan of care.
The care manager must document a need for transportation to support an individual's identified goals. The Health Home Care Manager will include justification for this service within the Person-Centered Plan of Care. For individuals not enrolled in a Health Home, MCO Care Coordinator, or the Independent Evaluator will be responsible for completing documentation of which goals in an individual's Plan of Care to which the trips will be tied.

For each participant utilizing Non-Medical Transportation, the Transportation Manager will provide a monthly report of authorized trips to the State.

Generally, the same rules used to determine reimbursement of trips to medical appointments should be followed when considering reimbursement of non-medical trips for eligible participants. Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver.
The following guidelines apply to Non-Medical Transportation:
• Transportation must be tied to a goal in the Plan of Care.
• Transportation is available for a specified duration and annual cost.
• Individuals receiving residential services are ineligible for Non-Medical Transportation.
• Use transportation available free of charge.
• Use the medically appropriate mode of transportation.
• Travel within the common marketing area.
• When possible, trips should be combined.
• Justify need for travel outside the common marketing area.
• Vouchers submitted for personal vehicle mileage reimbursement must be submitted within 90 days of the date of service. Only when there are extenuating circumstances, will the Department allow payment for trips that are submitted after the 90 day time period. These requests will be considered on a case-by-case basis provided valid justification is given.
• Reimbursement for travel can be denied when the destination does not support the participant's integration into the community.
• A participant's Plan of Care outlines the general parameters of his or her Non-Medical Transportation needs. However, these needs can change or be amended based upon the participant's stated goals and/or successful ongoing integration into the community.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Transportation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All children are eligible for this service regardless of whether they are in the managed care or FFS delivery system. This service is delivered outside of the MCO contracts. All non-medical transportation is billed via the FFS delivery system. Agencies interested in providing Non-Medical Transportation must be enrolled in the FFS program as a current Medicaid Transportation Provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its designee

Frequency of Verification:

Initially and at least every 3 years thereafter State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care - Expressive Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.

• Expressive Therapy (art, music and play) – Help children better understand and express their reactions through creative and kinesthetic treatment

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Expressive Therapy (art, music and play) – Help children better understand and express their reactions through creative and kinesthetic treatment. Limited to the lesser of four appointments per month or 48 hours per calendar year. This limit can be exceeded when medically necessary.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Home Health Agency (CHHA)
Agency	Provider Agency
Agency	Hospice Organization
Agency	Article 28 Clinic

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York ,a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must work within a child serving agency or agency with children's behavioral health and health experience designated through the NYS Children's Provider Designation Review Team to provide the services referenced in the definition. This requires agencies to have the appropriate license, certification and/or approval in accordance with State designation requirements by OMH, OASAS, OCFS or DOH.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care
• Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York, a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, c certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care
•Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York ,a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care - Expressive Therapy

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care
• Expressive Therapy (art, music and play) Child Life Specialist with certification through the Child Life Council a Creative Arts Therapist licensed by the State of New York, a Music Therapist with a Bachelor's Degree from a program recognized by the NYS Education Department, or a Play Therapist with Master's Degree, from a program recognized by the New York State Education Department and a current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music and Play). Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care – Bereavement Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care – Bereavement Service is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other

specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.

• Bereavement Service – Help for participants and their families to cope with grief related to the participant's end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community
integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Bereavement Service – Help for participants and their families to cope with grief related to the participant's end- of-life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider. All others are limited to the lesser of 5 appointments per month or 60 hours per calendar year.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Agency	Article 28 Clinic
Agency	Hospice Organization
Agency	Certified Home Health Agency (CHHA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Bereavement Service

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must work within a child serving agency or agency with children's behavioral health and health experience designated through the NYS Children's Provider Designation Review Team to provide the services referenced in the definition. This requires agencies to have the appropriate license, certification and/or approval in accordance with State designation requirements by OMH, OASAS, OCFS or DOH.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Bereavement Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist, Licensed Creative Arts Therapist or a Licensed Mental Health Counselor, that meet current NYS licensing. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Bereavement Service

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care
Bereavement Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing. Direct service workers must have background checks.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Bereavement Service

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Bereavement Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Bereavement Service

Provider Category:
Agency
Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Bereavement Service A Licensed Clinical Social Worker (LCSW), a Licensed Master Social Worker (LMSW), a Licensed Psychologist or a Licensed Mental Health Counselor, that meet current NYS licensing. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care – Massage Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care – Massage Therapy is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to their illness.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Massage Therapy –Limited to no more than 12 appointments per calendar year. This limit can be exceeded when medically necessary.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Organization
Agency	Certified Home Health Agency (CHHA)
Agency	Article 28 Clinic
Agency	Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Massage Therapy Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Massage Therapy Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
- Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
- Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
- The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
- Mandated Reporter
- Personal Safety/ Safety In The Community
- Strength Based Approaches
- Suicide prevention training
- Domestic Violence Signs and Basic Interventions
- Trauma Informed Care

Massage Therapy Massage Therapist currently licensed by the State of New York. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Massage Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must work within a child serving agency or agency with children's behavioral health and health experience designated through the NYS Children's Provider Designation Review Team to provide the services referenced in the definition. This requires agencies to have the appropriate license, certification and/or approval in accordance with State designation requirements by OMH, OASAS, OCFS or DOH.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.
For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care
Massage Therapist - A Licensed Therapist that meets current NYS licensing. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Entity Responsible for Verification:
DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Palliative care – Pain and Symptom Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care – Pain and Symptom Management is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness. The goal is to improve quality of life for both the child and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a child's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment.
Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21.
Types of activities included: Bereavement Therapy; Pain and Symptom Management; Expressive Therapy (Art, Music and Play); and Massage Therapy.
• Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition (examples: Acupuncture, meditation. see www.getpalliativecare.org)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit characteristics and qualities most often articulated by the individual child/youth and family/caregiver as key determinants of independence and community integration. Services should be offered in the setting least restrictive for desired outcomes, including the most integrated home or other community-based settings where the beneficiary lives, works, engages in services and/or socializes. While remaining inclusive of those in the family and caregiver network, family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit

Palliative care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

Pain and Symptom Management – Relief and/or control of the child's suffering related to their illness or condition. No limit; as required by participant's physician.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Article 28 Clinic
Agency	Hospice Organization
Agency	Certified Home Health Agency (CHHA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Pain and Symptom Management

Provider Category:
Agency
Provider Type:

Article 28 Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Pain and Symptom Management Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management) or a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medicine physician, board certified in Pediatrics. Direct service workers must have background checks

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Hospice Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Pain and Symptom Management Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management)or a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medicine physician, board certified in Pediatrics. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Palliative care – Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Certified Home Health Agency (CHHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Non-profit/voluntary/private as established in NYS Public Health Law §4004. Certified Home Health Agency (CHHA); PHL Sections 3602, 3606

Other Standard *(specify):*

Practitioners must operate in agencies which have been designated through the NYS Children's Provider Designation Review Team. This requires agencies have appropriate license, certification and/or approval in accordance with State designation requirements.
• Provider agencies and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
• Provider agencies adhere to cultural competency guidelines (See Appendix: HCBS Standards of Care)
• Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
• The provider agency ensures that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
• The provider agency ensures that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
• The provider agency ensures that any insurance required by the designating state agency is obtained and maintained.
• The provider agency ensures that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

For all staff providing Palliative Care Services it is expected that they will have a minimum of three years working with the medically fragile population and at least one year of clinical experience with pediatric population, preferably involving end of life care. Training must include:
• Mandated Reporter
• Personal Safety/ Safety In The Community
• Strength Based Approaches
• Suicide prevention training
• Domestic Violence Signs and Basic Interventions
• Trauma Informed Care

Pain and Symptom Management Pediatrician or Family Medicine Physician, board certified in Pediatrics or Family Medicine licensed by the State of New York, a Nurse Practitioner licensed by the State of New York (Pain and Symptom Management) or a Registered Nurse licensed by the State of New York under the direct supervision of a Pediatrician or medicine physician, board certified in Pediatrics. Direct service workers must have background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH or its Designee

Frequency of Verification:

Initially and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Under this benefit, Vehicle modifications are allowable (formerly called Home and Vehicle Modifications).

This service provides physical adaptations to the primary vehicle of the enrolled child which per the child's plan of care (POC) are identified as necessary to support the health, welfare and safety of the child or that enable the child to function with greater independence.

Service Components

Modifications include but not limited to: Portable electric/hydraulic and manual lifts, ramps, foot controls, wheelchair lock downs, deep dish steering wheel, spinner knobs, hand controls, parking break extension, replacement of roof with a fiberglass top, floor cut outs, extension of steering wheel column, raised door, repositioning of seats, wheelchair floor, dashboard adaptations and other ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

The Government Entity (for FFS enrollees) or MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services-Vocational

Rehabilitation (ACCES-VR). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. In FFS, the Governmental Entity is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected by the Governmental Entity (for FFS) through a standard bid process, following the rules established by the Office of the State Comptroller. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed. In managed care, the plan is the payer and may contract with an approved network provider for the technology. For Environmental Modifications, the Governmental Entity/MCO is the provider of record for billing purposes. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Vehicle Modifications are limited to the primary vehicle of the recipient.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by the Governmental Entity/MCO in conjunction with NYSDOH if exceeding established limits.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Vehicle Modifications

Vehicle Modifications are limited to the primary means of transportation for the child. The vehicle may be owned by the child or by a family member or non-relative who provides primary, consistent and ongoing transportation for the child. All equipment and technology used for entertainment is prohibited.
Costs may not exceed current market value of vehicle.

Other exclusions include the purchase, installation or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments, insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of modification: In most instances a specific type of Vehicle Modification is a one-time benefit to motor vehicles used by the child. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Accessibility Modification Limits
Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan, Medicaid State Plan under 1905(a) of the Social Security Act or other federal/state funding streams will be reimbursable under the HCBS Waiver.

Contracts for Vehicle modifications may not exceed $15,000 per year without prior approval from the Governmental Entity in conjunction with NYS DOH or the MCO. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Modification Contractor/Craftsman

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:

Modification Contractor/Craftsman

Provider Qualifications

License *(specify):*

Licensure appropriate to the trade

Certificate *(specify):*

Other Standard *(specify):*

Governmental Entity or MCO staff verify the qualifications of vehicle modification providers present the following knowledge and skills:
h. Must be familiar with the vehicle modification policies permitted in the waiver program as described in state guidance ; the Governmental Entity/HRA/MCO should supply the evaluator with a copy of both prior to initiation of the evaluation.
i. Must be able to communicate well with all parties involved with the development of vehicle modifications, e.g. consumers, contractors, and local government officials.
j. Must be able to clearly describe in writing, and by design, the proposed vehicle modification.
k. Must know and be able to apply the New York State Building Code, Current Accessibility Standards, and the Federal Accessibility Guidelines found in the Fair Housing Amendment Act (as relevant to any vehicle modification)
l. Must have knowledge of assistive technology and specific adaptive equipment appropriate for the child's needs.
m. Must have skill in design/drafting in order to clearly describe the proposed modification.
n. Must be able to complete all components of an On-Site Evaluation as in Section (x) of this manual.

Contractors performing any adaptation for a child in the waiver program is required to:
e. Be bonded;
f. Maintain adequate and appropriate licensure; g.

The ACCES-VR agency verifies the credential of vehicle modification providers pursuant to NYF Fire Prevention and Billing Codes, 00 OMM/ADM 4.

Verification of Provider Qualifications

Entity Responsible for Verification:

Governmental Entity or MCO

Frequency of Verification:

Provider qualifications are verified at the beginning of the vehicle modification contract by ACCES-VR.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Youth Peer Support and Training

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10050 peer specialist
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Please note that this waiver service was terminated on March 15th, 2020. It is now available to children via the State Plan under EPSDT SPA 20-0001.

Youth support and training services are formal and informal services and supports provided to youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the person-centered planning process and with the ongoing implementation and reinforcement of skills. Youth support and training is a face-to-face intervention and can occur in a variety of settings including community locations where the youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized care plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy goals, and to support their transition into adulthood.
Activities may include: Restoration, rehabilitation, and support to develop skills for coping with and managing psychiatric symptoms, trauma and substance use disorders; promote skills for wellness and recovery support; develop skills to independently navigate the service systems; develop skills to set goals; and build community living skills. Coaching to enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy; Self-Advocacy & Empowerment skill building to develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community; serve as an advocate, mentor or facilitator for resolution of issues; and, assist in navigating the service system including assisting with engagement and bridging during transitions in care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non Profit Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Youth Peer Support and Training

Provider Category:

Agency

Provider Type:

Non Profit Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

YPST is delivered by a New York State Credentialed Youth Peer Advocate. To be eligible for the Youth Peer Advocate Professional Credential, an individual must:
- Be an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the credentialing agency if the person has demonstrated competencies and
has relevant life experience sufficient for the youth peer-credential.
- Completed Level One (online) and Level Two (online and in person) training of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs followed by a minimum of three consultation calls.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a YPA including one from YPAs supervisor.
- Agree to practice according to the Youth Peer Advocate Code of Ethics.
- Documented 600 hours of experience providing Youth Peer Support services.
- Completed 20 hours of continuing education every 2 years.
- Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- Is able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Be supervised by a credentialed YPA OR a credentialed Family Peer Advocate, both with four years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595.
A YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:
- Is an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational credential can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
- Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- Is able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Submits two letters of reference attesting to proficiency in and suitability for the role of an YPA.
- Be supervised by a credentialed YPA OR a credentialed FPA, both with four years direct service experience OR an individual who meets the criteria for a “qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595. Refer to Supervisor Qualifications for specificity.
- Agree to practice according to the YPA Code of Ethics.

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA OR a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has:
- Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders.
- Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS).
- Completed a minimum of 46 hours content specific training, covering topics of advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of relative work experience or document at least 500 hours of related work experience if they:Have a Bachelor’s Degree, is certified by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training.

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA OR a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has: (Continued)
- Provided evidence of at least 25 hours of supervision specific to the to the performance domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Passed the NYCB/IC & RC Peer Advocate exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendations.
- Demonstrated a minimum of 16 hours specifically related to Youth Peer Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of ethics.

Supervisor Qualifications: YPAs will be supervised by:
1) A credentialed YPA with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization OR
2) A credentialed FPA with 4 years of experience providing FPSS that has been trained in YPST services and the role of the YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPAs within the organization.
3) A qualified “mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPA within the organization.
Additional Supervisor Qualifications:
- The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
- Supervision of these activities may be delivered in person or by distance communication methods.
- It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
- There may be an administrative supervisor who signs the youth peer specialist’s timesheet and is the primary contact on other related human resource management issues.
- Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.
Any child serving agency or agency with children’s behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.
The provider agency will assess the child prior to developing a plan of care for the child. Authorization of the plan of care is required by the DOH or its designee. Treatment services must be part of a plan of care including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Group should not exceed more than 8 members. Medicaid family support programs will not reimburse for the following:
- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA’s, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher’s aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary’s authorized plan of care.

- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's plan of care.
- Any intervention or contact not documented or consistent with the approved plan of care goals, objectives, and approved services will not be reimbursed.

Verification of Provider Qualifications

Entity Responsible for Verification:

NYSDOH will verify the agency's qualifications.

Frequency of Verification:

Verification of the Agency is conducted prior to signing the NYSDOH provider agreement, and thereafter, according to the applicable policy of NYSDOH State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☒ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Note: there is no option for Health Home so TCM was marked.

Children receiving HCBS will be enrolled in and receive care management from the Health Home program authorized under the existing Health Home State Plan. Children enrolled in MMC or HIV SNPs who receive HCBS and choose not to enroll in Health Home care management will have HCBS Eligibility determinations and their Plan of Care (POC) completed by the State Designated Independent Entity and the MCO will provide monitoring and oversight of all plan covered services including HCBS. Children eligible for HCBS and Medicaid under Family of One will be assessed by the State Independent Entity to determine HCBS/Medicaid eligibility prior to being enrolled in Medicaid and a Health Home. Children who choose not to enroll in Health Home care management and receive HCBS and are in FFS will have HCBS Eligibility determinations and their POC completed by the State Designated Independent Entity who will also provide monitoring and oversight.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

In accordance with Section 2899-a of the Public Health Law any entity that provides home and community based services (HCBS) to enrollees who are under twenty-one years of age under a demonstration program pursuant to section 1115 of the federal social security act must request a criminal history record check , by the New York State Department of Health (NYSDOH) and the New York State Division of Criminal Justice Services for each prospective employee who will provide HCBS services to such enrollees.
Note: this program will operate concurrently with the State's 1115 MRT waiver.

The term "employee" does not include persons licensed pursuant to Title 8 of the Education Law or Article 28-D of the Public Health Law, provided that such persons are operating within their Title, meaning that such license was required for the position. Volunteers are not subject to this requirement. Part 402 of Title 10 of the Official Compilation of Codes, Rules and Regulations for the State of New York (NYCRR) Part 402 establishes the process for conducting the criminal history record checks and the standards for review by NYSDOH. Each provider must develop and implement written policies and procedures that include protecting the safety of persons receiving services from temporary employees consistent with the NYS statutory requirements and regulations (e.g., appropriate direct observation and evaluation).

Criminal history record checks are finger print-based, national Federal Bureau of Investigation (FBI) criminal history record checks, which require the prospective employee's fingerprints, accompanied by two forms of identification, for submission. Providers must maintain and retain current records, including a roster of current employees who were so reviewed, to which NYSDOH shall have immediate and unrestricted access to the determination letters for the purpose of monitoring compliance with these provisions.

Verification of compliance with the criminal history record check regulations is an element of the NYSDOH surveillance process. At the time of surveillance, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background record check requirements. If a provider is found not to be in compliance, a statement of deficiency(ies) is issued, and the provider has to provide a plan of correction. The surveillance process is the State's annual on-site review audit process for MCOs. At the time of the surveillance on-site review, NYSDOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background record check requirements. If a provider is found not to be in compliance, a statement of deficiency(ies) is issued, and the provider has to provide a plan of correction.

Those providers that are transitioning to become Health Homes will be subject to regular auditing to ensure compliance with these and other requirements, as part of the affiliated Lead Health Home's redesignation process, which occurs at least every three years.
Those providers that will not be transitioning to become Health Home CMAs, but rather will continue as service providers, will be subject to the provider qualification monitoring process as outlined in each service description.

Criminal History Record Checks (CHRC) are finger print-based, national Federal Bureau of Investigation (FBI) checks that cover all unsuppressed criminal history records from NYS DCJS and a national check from the Federal Bureau of Investigation (FBI). The records, in many cases, go further back than 18. Especially where the individual was tried as an adult or adjudicated a juvenile delinquent (JD). Some matters, that are civil in nature, such as Family Court proceedings and Immigration matters, are suppressed and we do not receive records regarding these cases Providers of Home and Community Based Services (HCBS) to children under 21 years of age authorized under the Children's Consolidated 1915 (c)Waiver amendment will be subject to this requirement upon approval of this waiver amendment

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request

through the Medicaid agency or the operating agency (if applicable):

The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or
the operating agency (if applicable):
New York State requires that individuals applying to certain positions be checked against the Statewide Central Register prior to working with children. As per Section 424a of the Social Services Law, it is ultimately the responsibility of the provider agency to:
• Determine who has regular and substantial contact with children (employees, prospective employees, consultants, contractors and volunteers) within the agency;
• To contact the Statewide Central Register; and
• To receive and handle the response from the Statewide Central Register. Each provider develops its own procedures to ensure compliance.

The New York State Office of Children and Family Services maintains the Statewide Central Register of Child Abuse and Maltreatment (SCR, also known as the “hotline”) for reports made pursuant to Section 424a of the Social Services Law. The SCR receives telephone calls alleging child abuse or maltreatment within New York State. SCR staff relay information from the calls to the local CPS for investigation, monitors their prompt response, and identifies whether there are prior child abuse or maltreatment reports. The SCR receives calls 24 hours a day, every day from two types of sources: persons who are required by law (mandated) to report suspected cases of child abuse and maltreatment; and calls from non-mandated reporters, including the public.
- The type of staff for whom abuse registry screenings must be conducted: Any HCBS provider employee who has regular and substantial contact with children (employees, prospective employees, consultants, contractors and volunteers) within the designated waiver agency, ultimately the agency is responsible to determine what “substantial contact” means and who is subject to the screening.
- The entity or entities responsible for conducting the screening against the registry: Each provider agency is responsible for conducting the screening against the registry
The state process for ensuring that mandatory screenings have been conducted: DOH is the responsible party. DOH has a provider designation process where it has an MOU with the licensure agencies who perform limited activities for DOH including verification that mandatory screenings occurred as part of their licensure monitoring and report any and all issues to DOH. DOH through its record reviews or designees will review to ensure that each provider agency has conducted the screening for any HCBS provider employee who has regular and substantial contact with children. The screening is conducted against the registry maintained by the New York State Office of Children and Family Services called the Statewide Central Register of Child Abuse and Maltreatment (SCR, also known as the “hotline”) for reports made pursuant to Section 424a of the Social Services Law. Compliance with this requirement will be reviewed as part of the redesignation process, which will occur at least every three years.
- Method to monitor this process on a yearly basis due to the rate of turnover in staffing: compliance with this requirement will be reviewed annually and as part of the redesignation process, which will occur at least every three years.
- Method used to conduct the reviews: part of the provider validation redesignation reviews that occur at least every 3 years.
- Consequences if a provider is found to be out of compliance: The remediation process is initiated when the MCO/HH/IE or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including the qualifications and training of a practitioner/provider agency such as lack of compliance with screening requirements. In such situations, the standard procedure is for NYSDOH staff, Interagency Monitoring Team, and MCO to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The provider must provide a plan of correction. NYSDOH staff, the IMT and MCO may collaboratively work with the provider to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant’s service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM or IEIE will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Community Residences	
Crisis Respite	
Crisis Residences	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

There is 1 bed assigned in each of the facilities to be used as a Respite bed for the HCBS Waiver Program.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residences

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Palliative care - Expressive Therapy	☐
Case Management	☐
Vehicle Modifications	☐
Adaptive and Assistive Equipment	☐
Palliative care – Bereavement Service	☐
Palliative care – Pain and Symptom Management	☐
Environmental Modifications	☐
Palliative care – Massage Therapy	☐

Waiver Service	Provided in Facility
Day Habilitation	☐
Community Habilitation	☐
Caregiver/Family Supports and Services	☐
Supported Employment	☐
Respite	☒
Non-Medical Transportation	☐
Prevocational Services	☐
Community Self-Advocacy Training and Supports	☐
Family Peer Support Services	☐
Crisis Intervention	☐
Youth Peer Support and Training	☐

Facility Capacity Limit:

All Children's Community Residences are 8-bed facilities.

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Crisis Respite

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Palliative care - Expressive Therapy	☐
Case Management	☐
Vehicle Modifications	☐
Adaptive and Assistive Equipment	☐
Palliative care – Bereavement Service	☐
Palliative care – Pain and Symptom Management	☐
Environmental Modifications	☐
Palliative care – Massage Therapy	☐
Day Habilitation	☐
Community Habilitation	☐
Caregiver/Family Supports and Services	☐
Supported Employment	☐
Respite	☒
Non-Medical Transportation	☐
Prevocational Services	☐
Community Self-Advocacy Training and Supports	☐
Family Peer Support Services	☐
Crisis Intervention	☐
Youth Peer Support and Training	☐

Facility Capacity Limit:

There are 2 6-beds and 4 8-beds crisis residences

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒

Standard	Topic Addressed
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Crisis Residences

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Palliative care - Expressive Therapy	☐
Case Management	☐
Vehicle Modifications	☐
Adaptive and Assistive Equipment	☐
Palliative care – Bereavement Service	☐
Palliative care – Pain and Symptom Management	☐
Environmental Modifications	☐
Palliative care – Massage Therapy	☐
Day Habilitation	☐
Community Habilitation	☐
Caregiver/Family Supports and Services	☐
Supported Employment	☐
Respite	☒

Waiver Service	Provided in Facility
Non-Medical Transportation	☐
Prevocational Services	☐
Community Self-Advocacy Training and Supports	☐
Family Peer Support Services	☐
Crisis Intervention	☐
Youth Peer Support and Training	☐

Facility Capacity Limit:

There are 2 6-beds and 4 8-beds crisis residences

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally

responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ( ) **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

NYSDOH maintains an open enrollment process for entities who are designated as meeting the HCBS provider qualifications as a Children's Medicaid waiver provider. NYSDOH has a multi-level process in conjunction with New York State licensing and certification agencies (OPWDD, OMH, OASAS, and OCFS) for assuring that the providers that serve waiver participants are qualified. Beginning April 1, 2019, providers of the following services must be designated to provide newly aligned Children´s HCBS services under the NYS Medicaid program (both fee–for –service Medicaid and Medicaid Managed Care): HCBS: Caregiver Family Supports and Services, Respite, Supported Employment, Community Self–Advocacy Training and Support, Day Habilitation, Community Habilitation, Palliative Care Bereavement, Palliative Care Massage Therapy, Palliative Care Expressive Therapy, Palliative Care Pain & Symptom Management, Prevocational Services. The remaining services are purchased goods where the vendor is not enrolled in Medicaid and the governmental entity (for FFS enrollees) or the MCO (for MC enrollees) is the provider of record. Staff will review the potential new agency's background and program qualifications to ensure the agency has the requisite knowledge and skills to provide the service(s) it proposes to provide. Included in this review is a check of the agency's Medicaid provider enrollment information, a comprehensive review of the agency's history, including their relevant experience with children with physical and/or developmental disabilities. The provider must submit an application to NYSDOH or its designee demonstrating compliance with the qualifications and competencies necessary to meet waiver participant needs. In addition, every provider of services must complete the eMedNY provider enrollment process to verify that it meets all federal and State requirements for Medicaid participation. Information is available to all potential providers on the DOH website with direct references to the Children's HCBS provider application or the eMedNY website. These websites explain the process and qualifications for the waiver services. Providers may also contact DOH staff or its designee for further information.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver providers providing waiver services who meet designation, licensure and certification requirements continuously. (percentage = providers meeting requirements /total providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:

State HCBS provider designation files; MCO credentialing files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO/EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of waiver providers providing waiver services who meet designation, licensure and certification requirements prior to furnishing waiver services initially. (percentage = providers meeting requirements prior to furnishing services/total providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
State HCBS provider designation files; MCO credentialing files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO/EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of waiver providers providing waiver services who have an active agreement with the State or MCO. (percentage = providers with active agreements /total providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
State HCBS provider designation files; MCO credentialing files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO/EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of providers of waiver services who meet training requirements (percentage = provider who meet training requirements/total providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Training verification records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95% CI
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

MCO/EQRO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of providers of waiver services who meet training requirements (percentage= provider who meets training requirements/total providers)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% CI
☒ **Other** Specify: MCO/ EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH/IE or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including the qualifications and training of a practitioner/provider agency.

In such situations, the standard procedure is for NYSDOH staff, MCO and Interagency Monitoring Team to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The provider must provide a plan of correction. NYSDOH staff, MCO and the IMT may collaboratively work with the provider to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant's service, NYSDOH staff and MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM or IEIE will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

Unsatisfactory accessibility modification and adaptive and assistive equipment contractors will be notified of their disqualification from further service by the administering governmental entity (LDSS or DDRO) or MCO. The HHCM or IEIE will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO/ IE staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO, IE and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

NYSDOH will initially verify provider designation status through the web-based online portal system, assuring providers are approved and active, before they are authorized to provide Wavier services. The MCO is also responsible for verifying the status of each Waiver services providers through their credentialing processes. The Plan will maintain up-to-date credentialing files for all Waiver services providers. Provider designation will be reverified at least every three years by NYSDOH or its designee.

NYSDOH issues guidance to all Waiver services providers regarding required trainings through the HCBS Provider Services Manual. Individual waiver service practitioners are required to complete training on the required topic areas before they are qualified to begin providing direct Waiver services to participants. Waiver service providers are required to maintain training records on all staff and verify training had been completed before the staff can initiate service provision. The records are required to be made available to the NYSDOH or its designee at the time of site visits for compliance review.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State assures that this waiver will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan (note: this has been submitted but not yet approved). The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to the waiver when it submits the next amendment or renewal.

Waiver services are provided either in a HCBS eligible setting (the child's home) and/or in the community. The only service that would be in a setting would be respite which is excluded from the settings rule.

Eligible home settings for foster care children include Family Boarding Homes, Agency Operated Boarding Homes and Group Homes, with Not-for profit voluntary agencies (VAs) typically providing oversight that is monitored by governmental agencies. VAs must have Corporate authority and an operating certificate from OCFS to provide foster care services in settings with 12 beds or less (Foster Boarding Home Program, Agency Operated Boarding Home or Group Home), have sufficient administrative and fiscal viability; sufficient community standing; and the capacity and willingness to comply with Medicaid and Provider Agreement requirements. All eligible HCBS settings are free standing homes in the community. The homes have all the features one would find in a typical private home including kitchens with cooking facilities, communal dining areas, living space for leisure time activities and sleeping space. Access to the kitchen with cooking facilities is limited due the age of the children and related disabilities. Since the homes are located within the community, there is ready access to activities and facilities available to the general population of the locale. The children are able to access the community and the services fairly, freely and have the opportunity to build meaningful relationships with community members and community organizations.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

A Care Manager in the State of New York is employed by a Health Home (HHCM) OR by a Care Management Agency (CMA) who is contracted to provide care management for the Health Home through a Business Associate Agreement. For children opting out of Health Homes, the Independent Evaluator employed by the State's Independent Entity (IEIE called the C-YES Program) will perform all HCBS case management functions for FFS and managed care enrollees, except that MCO Care Coordinators will perform on-going POC monitoring for MCO enrollees opting out of Health Homes.

A Health Home Care Manager (HHCM) or Independent Entity Independent Evaluator (IEIE) must attend a training (online or in-person) and complete a certification exam with a minimum reliability score of 0.70 (online).

In addition, an HHCM must have the experience required to meet the care planning needs of the child as determined by, but not limited to, acuity (as measured by the CANS-NY, and/or the children's overall needs), presence of a single qualifying or co-occurring conditions, including Serious Emotional Disturbance, Complex Trauma, co-occurring medical or co-morbid conditions. Staff qualifications for care managers that serve children with an acuity level of "high" as determined by the CANS-NY are:
• A Bachelors of Arts or Science with two years of relevant experience, or
• A License as a Registered Nurse with two years of relevant experience, or
• A Masters with one year of relevant experience.

For children with a high acuity that are enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply. Those qualifications are a minimum of one of the following educational or service coordination experience credentials:
i. two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
ii. one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
iii. one year of service coordination experience and an Associates degree in a health or human service field; or
iv. a Bachelors degree in a health or human service field. Demonstrated knowledge and understanding in the following areas:
i. infants and toddlers who may be eligible for early intervention services;
ii. State and federal laws and regulations pertaining to the Early Intervention Program;
iii. principles of family centered services;
iv. the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
v. other pertinent information.

An IEIE must be a graduate of an accredited nursing program who holds a current New York license as a registered nurse. The IEIE must also have at least two years of RN experience in home care.

MCO Care Managers must have experience in health care, social work, nursing and/or long term care and be trained in the Contractor's procedures. Specifically for children under the Children's Behavioral Health and HCBS MCO amendment, care managers may also be Licensed Psychoanalysts, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, or Licensed Master Social Workers with experience in managing care for the target subpopulations including high-risk groups, such as children with SED, with co-occurring major mental disorders and SUD, who are involved in multiple services systems (education, justice, medical, welfare, and child welfare), in foster care. Care managers for children with medical fragility/complex medical conditions requiring significant medical or technological health supports must have qualifications and experience and knowledge specific to that population. All children's HCBS MCO care coordinators must have knowledge and experience in Children's health and behavioral health services, HCBS, EBPs, EPSDT services and social service programs.

The Children's Waiver, Health Home and the Independent Entity case management comply with all federal Conflict of Interest (COI) requirements for the 1915(c) waiver authority.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Safeguards
The 1915(c) will ensure choice of Case manager (either HHCM or IEIE). The Children's Waiver, Health Home and the Independent Entity case management comply with all federal Conflict of Interest (COI) requirements for the 1915(c) waiver authority. The HH will:
- Full disclosure to participants if a CMA also provides direct services,
- Participants will have freedom of choice of Health Home providers with the MCO and IE controlling the participant choice process,
- Participants will be provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development,
- Children will have a clear and accessible grievance and appeal process as well as an alternative dispute resolution process;
- The provider agency that develops the person-centered service plan must administratively separate the plan development function from the direct service provider functions. Specifically, Health Homes that provide care management and direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.
- Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.
- DOH will conduct annual case record reviews to ensure that participants have been informed of their rights, have had an assessment of risk, full information about availability of provider choice, services, frequency and duration
DOH will provide periodic evaluation of each Health Home to assure that Care Management Agencies that are also a direct service provider comply with the safeguards above.

The IE will provide no services to any participants.

The parents/legal guardians, along with the waiver applicant/participant as appropriate, actively participate in the development of the plan of care and selection of service providers and lead the person-centered planning process where possible. The parents/legal guardians, along with the waiver applicant/participant as appropriate, may include people chosen by them. The person centered planning process will be timely and occur at times and locations of convenience to the parents/legal guardians and the waiver applicant/participant, as appropriate.

Upon application, the HHCM/IEIE is responsible for providing the applicant's parent(s)/legal guardian(s) with information about waiver eligibility and enrollment criteria, and the various options for service. The applicant's parents/legal guardians are informed of their choice of system of care; institutionalization or community based waiver program, as well as the choice of available waiver services and waiver service providers. The parents/legal guardians of waiver participants must sign a Freedom of Choice Form that is witnessed and dated, indicating their decision to enroll the child in the Children's waiver program. The parents/legal guardians also sign the Choice of Case Management/Provider Selection form, indicating their choice of HH or IE and waiver providers for their child. A copy of each of these forms is given to the parent, and maintained in HH/IE. Each HH/IE has a list of available waiver providers that is shared with the participants and their parent(s)/legal guardians.

The waiver participant/participant's parent or legal guardian are assured certain rights, and must agree to certain responsibilities related to the waiver program. Once the participant/parent/legal guardian chooses the HHCM/IEIE, the HHCM/IEIE is responsible to work with the participant/parent/legal guardian continuously to:

• Provide an explanation of all services available to the child in the Children's waiver that may benefit the child. This information includes range of services offered through the waiver to prevent placement in skilled nursing facility, hospital or ICF/IID
• Provide assistance reviewing and understanding waiver material.
• Provide the opportunity to participant/parent/legal guardian to participate in the development, review, and approval of all POC meetings, including any change which ensures that the participant/parent/legal guardian has an active role in the POC development. The POC reflects all services to be provided to the participant including service type, frequency and duration. The POC is signed by the parent/legal guardian verifying that they have participated in the development of the POC.
• Provide the participant/parent/legal guardian choice of their child's service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Introduction
The HHCM/IEIE is the primary contact with NYSDOH staff, MCOs, and family of the applicant/participant. The MCOs will frequently communicate with service providers and HHCM/IEIE. HHCM/IEIE has the responsibility for ensuring that the plan for waiver services, referred to as the Plan of Care, is developed in accordance with waiver policy and protocols. For HH members, the HCBS is integrated into the Health Home comprehensive plan of care

Eligibility Evaluation/Assessment
The person centered planning process begins with the eligibility evaluation that includes the use of a portion of the CANS-NY assessment tool (for NF and Hospital LOC) or the OPWDD ICF-IID tool that documents the applicant's needs, and determination that the applicant needs skilled nursing facility, ICF/IID or hospital level of care as required for participation in waiver. If the participant is a member of a Health Home, the HHCM performs a complete CANS- NY assessment on the child. A complete CANS-NY is not necessarily conducted for individuals not in Health Home. The IEIE conducts the eligibility evaluation that includes the use of a portion of the CANS-NY assessment tool (for NF and Hospital LOC) or the OPWDD ICF-IID tool that documents the applicant's needs, and determination that the applicant needs skilled nursing facility, ICF/IID or hospital level of care as required for participation in waiver. The HHCM/IEIE uses the results of the eligibility evaluation and any additional assessments performed to develop a Plan of Care.

An eligibility re-evaluation is completed annually prior to every POC development by the HHCM or IEIE using an algorithm based on a portion of the CANS-NY assessment tool or the OPWDD ICF-IID tool. The full CANS-NY assessment is performed for all HH members. The eligibility evaluation outlines the participant's needs. The HHCM/IEIE utilizes this information in the development of the participant's plan of care.

The initial evaluation and re-evaluation takes into account the applicant's medical, social, habilitation and environmental barriers/needs, as well as the family's needs, strengths and abilities and is electronically signed by the HHCM/IEIE/Developmental Disabilities Regional Office (DDRO) staff member who conducts the evaluation.

Evaluation results are used to ascertain that the applicant needs skilled nursing facility, ICF-IID or hospital level of care as required for participation in waiver, and that the interventions are necessary for the child to be safely cared for at home or in the community.

During all steps of the eligibility evaluation/assessment process, the HHCM/IEIE remains in contact with the waiver applicant's parents/legal guardians. The HHCM/IEIE will assist with the Plan of Care Development including: scheduling the evaluation/assessment to accommodate the parent's schedule, serving as a conduit for the family to obtain information about the waiver, and informing the family of the choice of providers available to render the services.

Plan of Care Development
The HHCM/IEIE reviews all documentation to determine waiver eligibility and maintains copies of the documentation required for eligibility as well as any additional assessment information and necessary documentation. The POC is developed in a person-centered discussion with the child and family, surrounding the strengths and needs of the child and their development of Plan of Care. The Plan of Care will specifically outline the types of services to be provided to the child and family by their chosen providers

The HHCM or IEIE, with the assistance and input from the child's parent(s)/legal guardian(s), uses the information gathered from the evaluation/assessment to design a Plan of Care that will:
• Reflect that the setting in which the individual resides is chosen by the individual.
• Reflect the individual's strengths and preferences.
• Reflect clinical and support needs as identified through the eligibility evaluation/assessment of functional need.
• Include individually identified goals and desired outcomes.
• Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
• Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
• Identify the individual and/or entity responsible for monitoring the plan.
• Include a method for the individual to request updates to the plan as needed.
• Be finalized and agreed to, with the informed consent of the individual in writing, and signed by family/participant and providers responsible for its implementation.

For Children served by HH: A Comprehensive Plan of Care (POC) is developed through the coordination of information from the CANS-NY assessment, the HCBS Eligibility Determination, the Health Home comprehensive assessment, and the inter-disciplinary team meeting which is a discussion with the child, their family, supports, and involved providers.

Health Home care managers develop a single Health Home comprehensive plan of care that includes all services a child needs (health, behavioral health, community and social supports, specialty services etc.) The Health Home comprehensive plan of care will be updated or developed to include HCBS for children that are eligible for HCBS and enrolled in Health Home – Health Homes will ensure the Health Home care plans meets care plan requirements for HCBS.

For Children opting out of Health Homes and served by the Independent Entity: The IEIE will develop a plan of care utilizing the information HCBS Eligibility Evaluation and a discussion with the child, their family, supports, and involved providers.

The POC must be signed by the responsible parent, guardian or legally authorized representative and the child/adolescent, if age appropriate. All involved providers, inclusive of the HCBS providers will be involved in the development of the POC and be given the opportunity to sign the POC whenever it is revised for any reason. However, at a minimum, the parent, guardian, legally authorized representative and/or child must sign the POC at least once, prior to submitting the completed POC. Updated and revised POC should also have the family and/or child/adolescent signatures, otherwise proper documentation would be needed in the care record how their input was part of the updated/revised POC and why a signature could not be obtained.

The HHCM/IEIE will submit the child's POC to the MCO, if applicable.
The HHCM/IEIE will follow up with the family at regular intervals to ensure linkage to services and that no changes are necessary. Contacting the child, parent, guardian, and legally authorized representative throughout the referral/intake process.

The IE will forward a Medicaid application including a coversheet documenting that the child has been determined functionally eligible for aligned children's HCBS and has a POC developed if the child does not have Medicaid to the local district. The LDSS will ensure that financial eligibility is completed and enrollment in Medicaid is completed.

Plan of Care Update
The Plan of Care must be updated at a minimum annually, and reviewed every six months to clearly identify the current needs of the child. The plan must support that the participant's needs can be met through waiver services

Change in the participant's medical condition may require more frequent assessments of the child's needs and revision of all or part of his or her Plan of Care regarding the addition of necessary interventions or the removal of interventions for the child and family. The revised plan must be signed and dated by the HHCM/IEIE/MCO Care Coordinator (MCOCC) and the participant's parents/legal guardian as well as any affected providers.

An eligibility evaluation is completed annually prior to every POC development. The HHCM/IEIE/MCOCC utilizes information gathered in the eligibility evaluation and any additional assessments conducted in the development of the participant's plan of care.

The HHCM or IEIE/MCOCC for children opting out of the HH monitors and oversees the implementation of the POC through frequent communication with parents/legal guardians. The MCO also reviews the State Plan services in the POC monitoring for managed care enrollees.

Case Records Maintenance
The original approved and signed Plan of Care is maintained in the applicant's case file by the HHCM or IEIE and are made accessible to NYSDOH as needed. The MCO also maintains a copy of the approved Plan of Care for managed care enrollees.

Any subsequent approved revision of a participant's Plan of Care requires the participant's parent(s)/legal guardian's signature.

A copy of the participant's approved original Plan of Care and subsequent amendments are given to the participant and/or their parents/legal guardian.

The HHCM or IEIE is responsible for the coordination of services identified on the POC. The HHCM or IEIE works with the child's providers. This is accomplished by referrals with the physician, parents/legal guardian and other service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Since waiver participants are under the age of twenty-one most live at home with their parents, the needs of the family as whole must be taken into account when developing the child's plan of care. The caregiver back-up plan, schedule, and availability of the informal caregivers (parents/legal guardian and possibly others) are reflected in the plan of care and affect the scope, duration, mix of HCBS services that may be required.

The plan of care is reviewed at least every six months (more often for HH members). Any changes needed in the plan of care to assure the safety of the participant may be brought to the attention of the HHCM, MCOCC and IEIE or any caregiver at any time. The HHCM, MCOCC or IEIE oversees the implementation of any change to the waiver participant's plan of care.

The participant is always part of the plan of care development. Participant's needs and preferences are discussed with the care manager when developing the plan of care. HHCM or IEIE take into account the participant's preferences in developing strategies to mitigate potential and perceived risks which are set out and addressed in the plan of care.

The parents/legal guardians are given the HHCM or IEIE contact information to assist the participant/parent/legal guardian in problem solving as needed.

MCOs must provide data to Health Homes and/or care management agencies to assist in outreach and engagement efforts, subject to any required agreements for sharing Medicaid Confidential Data in accordance with HIPAA and other state requirements regarding confidentiality. MCOs must include information in the Health Home Welcome Letter that encourages potentially eligible members to enroll in a Health Home by including a brief summary of the services and benefits provided by the Health Home. MCOs must continue periodic education to eligible members until member enrolls in a Health Home. This includes identifying opportunities for Health Homes to reengage in outreach (e.g., appearance at emergency room or inpatient hospitalization) and reassigning the member to a Health Home.

HHs and MCOs have hotlines and other emergency contact information that can be included in the plan. Each family opting out of HH will be given the information for the IE to contact if a change in services or other issue arises. The HH, MCO, and IE can determine if emergency or crisis providers should be contacted or if other providers are needed to be called for back-up if health and welfare are jeopardized.

Individuals who are 18 years of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice to disenroll from the HH and enroll in the IE during the HCBS enrollment process and each annual reevaluation or at anytime the individual/family contacts the Health Home.

For individuals who may choose not to enroll in Health Home but are eligible and wish to receive aligned children's HCBS, the Health Home care manager will explain this means they will not be able to access comprehensive Health Home care management services, but will still be required to work with an entity (i.e., the State's Independent Entity) to develop an HCBS POC that is required to access HCBS. The Health Home Care Manager, with appropriate consents from the child/family or legally authorized representative or guardian, will assure individuals who decline Health Home enrollment are referred to the State's Independent Entity. The Independent Entity will develop a person-centered plan of care for provision of HCBS. For children who are enrolled in Medicaid managed care, the MMCP will monitor access to care and coordinate with the Independent Entity to maintain the HCBS plan of care. For children who are not enrolled in a Medicaid Managed Care Plan, the Independent Entity will work with the State to monitor access to care, including HCBS, delivered via Medicaid fee-for-service.

For the child who is not yet Medicaid eligible and is newly in need of services, the local referral will be made to the Independent Entity. With the appropriate consents from the child/family or legally authorized representative or guardian, the Independent Entity will confirm the child is likely to be eligible for Medicaid, Health Home and/or HCBS; and:
- Perform HCBS Eligibility Determination (i.e., determine if the child meets target population, risk and functional HCBS eligibility criteria);
- If HCBS eligible, assist the family in completing the Medicaid application and submit the application to the local social service district;
- Refer the child and family to the Enrollment Broker for help with plan selection; and
- Once determined eligible for Medicaid, assist the child with Health Home selection and referral (As part of the IE eligibility process, if the child is found eligible for HCBS and Medicaid, the child/family will be given a choice of Health Home. During that choice period, the IE will explain to the child/family that they have an option to opt out of the Health Home at any time consistent with the Health Home requirements) or

- If the child opts out of Health Home, develop an HCBS plan of care, inclusive of the child and family's goals,
- If the child enrolls in an MCO, share the HCBS POC with the MCO; and
- If the child remains in FFS, monitor access to care.

For children who are enrolled in HH, the HH is responsible for implementing the plan of care. The HH will coordinate State Plan services and the HCBS on the plan of care under 1945 of the Social Security Act. For children who have opted out of the HH and are enrolled in the MCO, the MCO is responsible for coordinating, implementing and monitoring the State Plan services and the HCBS on the plan of care under the managed care contract. For children who have opted out of the HH and are receiving all services under FFS, the IE is responsible for the implementing and monitoring Medicaid services/the HCBS plan of care under administrative case management.

The Health Home comprehensive assessment will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making. For children participating in the IE, the IEIE will provide the information regarding services available under the waiver.

The back-up plan may include provider agency contacts, school contacts, neighbors, religious and extended family available in the case that a worker is not available or there is an emergency.

An assessment of the participant's level of skills, and dignity of risk are identified during the service plan development process through person-centered planning. To evaluate "risk" and the individual's responsibility and ability to calculate the risk, the participant, the HHCM/IEIE take into consideration the benefits to the individual and the rights of the individual, ways to empower the person to improve their ability to make informed decisions through education and self-advocacy skills, possible resources and environmental adaptations that can allow the person to take the "risk," but mitigate potential hazards.

The assessment will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making. The care manager will assess for risk factors that will include but not limited to HIV/AIDS; harm to self or others; persistent use of substances impacting wellness; food and/or housing instabilities

The parents/legal guardians are given the HHCM or IEIE contact information to assist the participant/parent/legal guardian in problem solving as needed.

In order to assure the health and safety of each waiver participant, the plan of care must account for the safety of the individual. Safety is essential to successful waiver participant and is a key consideration in plan of care development. All plans of care must demonstrate that the participant can be cared for in the home or community and is able to access necessary/wanted community services. The assessment and plan of care must address necessary home modifications, vehicle adaptations, and/or durable medical equipment that will benefit the waiver participant and allow caregivers to provide services for the child safely. In addition, the plan of care must identify supports needed to keep the participant safe from harm and actions to be taken when the health or welfare of the person is at risk. Safety is a significant issue discovered during the planning process that are individualized and specific to the participant; these include relevant medical and behavioral information.

Family of One children will be found functionally eligible by the IE before they have Medicaid eligibility. The IE will work with the local offices to determine financial eligibility. On-going functional eligibility for.

Family of One children will be determined by the HHCM or IEIE depending upon the CM option the child chose. On an on-going basis, the local offices will determine financial eligibility for all children.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The HHCM or IE must offer all applicants/participant's the choice of available HCBS and providers. The HHCM or IE is responsible for making sure that the waiver applicants/participants and their parents/legal guardians know of the participant's right to choose and change service providers, and that the HHCM or IEIE will assist the participant in doing so.

The HHCM or IE is also required to provide all applicants/participants with verbal and written notice of their rights under Medicaid.

The HHCM or IE ensures that the participant understands his/her choice regarding services and providers. The HHCM/IE maintains the list of available providers in the county (and in each MCO).

The HH/IE provides the participant and or parents/ legal guardians with a list of approved HHCM or IE and encourages the parents/ legal guardians interview potential CMs/IEs. The parents/legal guardians select the Care manager/IE of their choice and signs and date the Choice of Care Management/Provider Selection form.

The State's standard is the HH. The Independent Entity option was created because HH cannot be mandated and NY may not condition the receipt of HCBS on receipt of another service such as HH. Under the IE option, the plan of care is reviewed less often for individuals who opt out of HH and do not want the level of contact that a HH will maintain. This is because there will be a small number of individuals (e.g., children with TPL, Family of One children, children who have had their target criteria for a long length of time, etc) who do not desire to have contact with a HHCM according to the HH acuity contact schedule or who do not need to have the level of contact required by HH standards including appointment reminders, arranging for transportation, etc). These individuals may opt out of the HH and continue to receive HCBS services.

Health Home are fully aligned comprehensive care management available to children so that there are only two options/choices for children (Health Home) or administrative case management through the Independent Entity with follow-up by the MCO if the child is enrolled in managed care.

Option 1: Health Home. Regular FMAP rate. 1945 of the Social Security Act – HH SPA. Children eligible for and Opting into the Health Home:
- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Enrollee and Family Support
- Referral to Community and Social Supports
- Use of Health Information Technology to Link Services

Option 2: Independent Entity - Children opting out of the Health Home. Medicaid Administrative Match for the Independent Entity with the MCO paid for through the capitated rate Administrative Case Management. State Medicaid Manual 4302.2 for the Independent Entity and 42 CFR 438.208(c). The HCBS person-centered planning be performed by an administrative entity called the Independent Entity. The Independent Entity is also the State's Enrollment Broker (Maximus) and independent of all Health Homes, HCBS providers, MCOs and State Plan providers. It is used to only arrange for Medicaid services such as HCBS and includes four required elements:
- Assessment;
- Development of a Plan of Care;
- Referral to HCBS services; and
- Monitoring of HCBS

For children enrolled in managed care, the initial HCBS eligibility evaluation and HCBS person-centered planning will be performed by the Independent Entity. Subsequent evaluations will be performed by the IE and subsequent Person-Centered Planning referral and monitoring will be performed by the MCO.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Once functional eligibility has been determined within the UAS, NYSDOH also determines if there is capacity within the waiver (i.e., slot available) and communicates with the HHCM/IEIE that enrollment may proceed and the POC is developed. NYSDOH will maintain communication with the HHCM/IE until resolution of any questions or concerns regarding the provision of necessary services to maintain the applicant at home or in the community.

MCOs, HH and IE are routinely in contact with the families and providers regarding waiver applicants and services rendered to the waiver participant. MCOs, HHCMs and the IEIE monitor plans of care). If corrective actions are indicated, the MCOs or State staff will notify the provider in writing as to the actions necessary to remedy the situation. MCOs, NYSDOH or its designee will also evaluate the documentation from the plans of care against claim data acquired through the MCO claims payment or the FFS eMedNY to assure that services have been appropriately delivered in accordance with the approved plan of care. (For description of eMedNY, see section I-1).

The MCO, HHCM or IEIE can request adjustments to the plan of care, either at time of application, at the six month review or any time during the review period when the MCO, HHCM or IEIE determines that the proposed or implemented POC will not meet or is not meeting the needs of the applicant/waiver participant. If the necessary parties (providers, MCO, HH/IE, and applicant/parent) cannot agree, the MCO Medical Director or NY Medical director or his/her designee will review case documentation and take action to resolve the situation. NYSDOH staff provide technical and professional assistance to the HHCM or IEIE as needed.

The HH/IE/MCO review all enrollment and annual reevaluation documentation. This includes Application form, Freedom of Choice form, Choice of Case Management/Provider Selection form, proof of age, proof of physical disability, proof of Medicaid eligibility, Level of Care, care management selection, MD orders (if any), and Plan of Care. Annually, the NYSDOH staff or its designee completes a statistically significant record reviews.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**

☐ **Other**
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Safeguards

The 1915(c) will ensure choice of Case manager (either HHCM or IEIE). The Children's Waiver, Health Home, and the Independent Entity case management comply with all federal COI requirements for the 1915c authority. HH will:
• Full disclosure to participants if a CMA also provides direct services,
• Participants will have freedom of choice of Health Home providers with the MCO and IE controlling the participant choice process,
• Participants will be provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development,
• Children will have a clear and accessible grievance and appeal process as well as an alternative dispute resolution process;
• The provider agency that develops the person-centered service plan must administratively separate the plan development function from the direct service provider functions. Specifically, Health Homes that provide care management and direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.
• Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.
• DOH will conduct annual case record reviews to ensure that participants have been informed of their rights, have had an assessment of risk, full information about availability of provider choice, services, frequency and duration.

DOH will provide periodic evaluation of each Health Home to assure that Care Management Agencies that are also a direct service provider comply with the safeguards above.
The IE will provide no services to any participants.

In addition to reviewing and approving each plan of care, the HH/MCOCC/IE continually monitors the plan of care. The MCOCC monitors any services on the plan of care for managed care enrollees. The HHCM or IE/MCOCC maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH staff. Identified issues are addressed directly by the HHCM or IE or referred NYSDOH or the MCO for review and recommendations. The waiver participant/parents may contact the HHCM, IE, MCOCC or NYSDOH staff at any time to discuss issues. Information about this process is relayed to all 1915(c) waiver applicant families at the time of application.

HHCM or IE/MCOCC maintain open communication with all participants and their families. If services are not being provided, the participant/parent/legal guardian contacts the HHCM or IE, or MCO (if applicable). The HHCM and IE/MCOCC are in regular contact with the participant/parent/legal guardian to assess if services are being provided and back up plans are sufficient. If problems occur, the HHCM or IE/MCOCC works with the MCO or NYSDOH staff and participant/parent/legal guardian to obtain additional services.

Any discrepancies between the plan of care and actual delivered services are identified through a range of methods including retrospective reviews of the plans of care, a retrospective paid claims review, provider surveillance, and/or information received by the HHCM, MCO, IEIE and/or NYSDOH staff. When problems are identified, further investigation is begun by an on-site visit to provider, or through formal referral to the appropriate agency for audit and review.

On a routine basis, NYSDOH staff monitors the program in conjunction with the Interagency Monitoring Team. Random review of cases are conducted by comparing paid claims to services authorized in the plan of care and parents of the participant are asked to certify that certain waiver services were provided and completed in accordance with an approved POC Every waiver participant must have a recipient restriction/exception (R/E) code on his or her Medicaid enrollment file that identifies the child as a Children’s waiver participant. The eligibility worker is responsible for putting the Children’s R/E code and effective date on the participant’s WMS file.

Waiver service delivery is also monitored through participant feedback, such as the CAHPS survey of managed care members, to gather input about their experiences in the managed care program.

When NYSDOH or its designee or the MCO conducts a random review of all Children’s cases, the HH/IE/MCOCC is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re- assessment period, as appropriate by NYSDOH. If issues are noted by the HHCM, IE, MCOCC, NYSDOH or another oversight agency, NYSDOH staff in conjunction with the HH/IE/MCOCC,

will conduct a case review including POCs, paid claims, and other documentation from waiver participants/parents. Written reports and, if necessary, correction plans may be required. If services continue to be out of compliance with the participant's POC or inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

NYSDOH staff, the MCO, and HH/IE monitors whether participants are afforded choice of providers, whether services are meeting their needs, whether back up plans are effective and participants' health and welfare is being maintained through a variety of mechanisms. These include: monitoring of complaint calls, HH,MCO, IE reports, monthly conference calls, care manager calls, and care manager reports. If trends are noted or problems arise, NYSDOH or MCO holds a conference call with the HHCM or IEIE/MCOCC and participant/family/legal guardian if needed to address the situation or resolve the issue.

In addition to reviewing and approving each plan of care, the HH/IE continually monitors the plan of care. The HHCM or IE maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH staff. The HHCM maintains contact as required by the schedule of contacts as required by the acuity of the child according to the health home contact schedule. The IEIE maintains semiannual or quarterly contact respectively.

The waiver participant/parents may contact the HHCM, IE or NYSDOH staff at any time to discuss issues. Information about this process is relayed to all 1915(c) waiver applicant families at the time of application. HHCM or IEIE maintain open communication with all participants and their families.

Specific monitoring methods are addressed below:
Identified issues are addressed directly by the HHCM or IE or referred to NYSDOH for review and recommendations.

- Services furnished in accordance with the service plan;
If services are not being provided in accordance with the service plan, the participant/parent/legal guardian contacts the HHCM or IEIE, or MCO (if applicable). The HHCM and IE/MCOCC are in regular contact with the participant/parent/legal guardian to assess if services are being provided and back up plans are sufficient.
- Participant access to waiver services identified in service plan;
Any discrepancies between the plan of care and actual delivered services are identified through a range of methods including retrospective reviews of the plans of care, a retrospective paid claims review, provider surveillance, and/or information received by the HHCM,MCO, IE, and/or NYSDOH staff.

On a quarterly basis, NYSDOH staff monitors the program in conjunction with the Interagency Monitoring Team. Random review of cases are conducted by comparing paid claims to services authorized in the plan of care and parents of the participant are asked to certify that certain waiver services were provided and completed in accordance with an approved POC.

The New York State Department of Health (NYSDOH) sponsors a member experience survey every other year for adults enrolled in Medicaid managed care plans. The Department uses the results from this biannual survey to determine variation in member satisfaction among the plans and issues a statewide Continuous Quality Improvement Report to improve quality and track issues identified in the survey.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. CAHPS, a program of the U.S. Agency for Healthcare Research and Quality, provides nationally used surveys that cover topics that are important to consumers, such as communication skills of providers and ease of access to healthcare services, health care providers and health plans.

DataStat, Inc. conducts the survey on behalf of the NYSDOH using the CAHPS 5.0H Adult Medicaid survey. There is a statewide summary report for Medicaid Managed Care plans, and there are 15 plan specific reports. There is also a statewide summary report for HIV Special Needs Plans and 3 plan specific reports.

- Participants exercise free choice of provider;
NYSDOH staff, the MCO, and HH/IE monitors whether participants are afforded choice of providers, whether services are meeting their needs, whether back up plans are effective and participants' health and welfare is being maintained through a variety of mechanisms. These include: monitoring of complaints, MCO, HH, IE reports, monthly conference calls with contractors, care manager calls, and care manager reports. All reports are monitored. The CM conducts the

health and welfare calls as required by the type of Care Management (HH-monthly, MCO- quarterly, IE for FFS – semiannually). If there are issues found, the NYSDOH or MCO holds the conference call as noted. If trends are noted or problems arise, NYSDOH holds a conference call with the HHCM or IEIE/MCOCC and participant/family/legal guardian if needed to address the situation or resolve the issue. The annual case record review performed by DOH will also ensure that free choice forms were completed as required.

- Services meet participants' needs;
The HH/IE/MCOCC continually monitors the plan of care to determine if the services meet participants' needs. The participant/parent/legal guardian may also contact the HHCM or IEIE or MCO(if applicable) if there is an issue. The HHCM or IEIE/MCOCC maintains contact with the waiver applicants and their parents/legal guardians, waiver providers and NYSDOH staff. according to the acuity of the child and the HH contact schedule. The IEIE/MCOCC maintains semiannual or quarterly contact respectively.

- Effectiveness of back-up plans;
The participant/parent/legal guardian contacts the HHCM or IEIE/MCOCC, if there is an issue. The HHCM and IEIE/MCOCC are in regular contact with the participant/parent/legal guardian to assess if back up plans are sufficient.

-Participant health and welfare;
All MCOs must provide SDOH on a quarterly basis, in a manner and format determined by SODH, a report of critical incidents identified and/or investigated by the Contractor involving Enrollees in receipt of long term services and supports.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery.

The HH must inform the Department within 24 hours of notification from the CM.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

The IEIE must report any health and welfare concerns to DOH on a quarterly and annual basis. The Department will review the incident reported by the IE and make recommendations, if necessary, to ensure that the IEIE referred and investigated the incident as appropriate is appropriate and in compliance with established DOH Standards.

- Participant access to non-waiver services in service plan, including health services;
The participant/parent/legal guardian contacts the HHCM or IE, or MCO (if applicable) if access to non-waiver services in the service plan are not being delivered, including health services. The HHCM and IEIE/MCOCC are in regular contact with the participant/parent/legal guardian to assess if non-waiver services are being provided.
- Methods for prompt follow-up and remediation of identified problems.
If problems occur, the HHCM or IE/MCOCC works with the MCO or NYSDOH staff and participant/parent/legal guardian to obtain additional services. When problems are identified, further investigation is begun by an on-site visit to provider, or through formal referral to the appropriate agency for audit and review.

When NYSDOH or its designee or the MCO conducts a random review of all Children's cases, the HH/IE is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re- assessment period, as appropriate by NYSDOH. If issues are noted by the HHCM, IEIE, MCO, NYSDOH or another oversight agency, NYSDOH staff in conjunction with the HH/IE/MCO, will conduct a case review including POCs, paid claims, and other documentation from waiver participants/parents. Written reports and,

if necessary, correction plans may be required. If services continue to be out of compliance with the participant's POC or inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

NYSDOH OHIP aggregates of the annual random review of all Children's cases, claims, grievances, and incident reports from the MCO, HHs and IEs. If the NYSDOH identifies an issue, the HH/IE/MCO is notified in writing of any deficiencies and a corrective plan is noted. Depending upon the findings, corrective action may be required immediately or within the next re- assessment period, as appropriate by NYSDOH. If issues are noted by the HHCM, IEIE,MCOCC, NYSDOH or another oversight agency with licensing authority, NYSDOH staff in conjunction with the HH/IE/MCO, will conduct a case review including POCs, paid claims, and other documentation from waiver participants/parents. Written reports and, if necessary, correction plans may be required. If services continue to be out of compliance with the participant's POC or inconsistent with State and federal regulations, NYSDOH may take steps to terminate the provider's enrollment status.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participants reviewed with a POC that was adequate and appropriate to their needs and goals (including health goals) as indicated in the assessment(s). (Percentage= total number of plans of care that were adequate to needs and

goals/total number of cases reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% CI
☒ **Other** Specify: HH, MCO, and Independent Entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants reviewed with a POC that has adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s) (Percentage= total number of plans of care that address assessed health and safety risks/total number of cases reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants reviewed with a POC that addressed the participant's goals/needs as indicated in the assessment(s). (Percentage= total number of plans of care that addressed needs and goals/total number of cases reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percent of POC forms/processes completed as required in the waiver (percentage = number of compliant POC and processes/number of POC reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

HH, MCO, and Independent Entity		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participants whose POC was updated within 365 days of the last evaluation. (percentage = updated POC that were updated annually / records reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants whose POC was updated as warranted by changes in the participant's needs. (percentage = updated POC as warranted based on a significant life change/records reviewed with a significant life change)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews or through Utilization Review Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

HH, MCO, and IE		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: HH,MCO,and IE	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of new participants receiving services according to their POC within 45 days of approval of their POC (percentage = participants reviewed receiving services according to POC within 45 days/records reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews; financial claims records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants who received services in the type, amount, duration and frequency specified in the POC (percentage = participants reviewed receiving services according to POC/records reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews; financial claims records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

HH, MCO and IE		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and IE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participant records reviewed with a completed signed freedom of choice form that specifies choice was offered among waiver services and providers (percentage = records reviewed with FOC form/records reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH, MCO, and IE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and IE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participant records reviewed with a POC that includes the participant's and/or guardian/caregiver's signature as consistent with state and federal guidelines (percentage = records reviewed with signatures/records reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person-centered plan record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

HH, MCO, and Independent Entity		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH, MCO, and Independent Entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

NYSDOH, IMT, and MCOs monitor waiver and HH providers that operate in New York State by conducting standard periodic inspections that include State licensure, federal initial certification, and recertification surveys to ensure the agencies meets all governing Medicaid federal and State guidelines. The NYSDOH monitors the Independent Entity. All significant issues/deficiencies identified during such survey, or by complaint or any other means, must be shared with NYSDOH waiver management staff. Uncorrected deficiencies findings may jeopardize waiver provider status.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH/IE or NYSDOH staff or Interagency Monitoring Team identifies a lack in the quality of provided services or any other issue related to administration of waiver services including an issue with a HHCM or IEIE. During the annual case reviews, NYSDOH or its designee performs quality reviews of POC development, review and updates to ensure that the proper forms and processes are used, the POC revisions are made timely and when needed, the needs and goals of the child/family are addressed, and the federally required elements of a POC are incorporated. In instances when it is discovered that this has not occurred the team recommends that the HHCM or IEIE take steps to address the deficiency. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

In such situations, the standard procedure is for NYSDOH staff, Interagency Monitoring Team, and MCO to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The HH or IE must provide a plan of correction and address any issues at the child/family level. NYSDOH staff, the IMT and MCO may collaboratively work with the HH or IE to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM or IEIE will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

Unsatisfactory accessibility modification and adaptive and assistive equipment contractors will be notified of their disqualification from further service by the administering LDSS or MCO. The HHCM or IEIE will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO/IE staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO, IE and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
HH, MCO, or Independent Entity	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Children's waiver applicant/participant is informed of his/her fair hearing rights at the time of application for Medicaid benefits by the LDSS/HRA. The Medicaid application and MCO member materials includes information to the applicant regarding their general Medicaid rights. The participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing as part of the program information given to the member.

Additionally, the HHCM/IEIE ensures that the waiver applicant understands: his/her rights, access to case conferences and Fair Hearings as they proceed through the waiver enrollment process, and throughout the duration of the participant's waiver enrollment.

Eligibility
Once the application for the Children's waiver program has been reviewed an automated acceptance/denial is generated for the HHCM/IEIE. The Health Home/IE issues a Notice of Determination/Decision (NOD) to the applicant based on that automated acceptance/denial. A Notice of Determination/Decision (NOD) is written documentation from the Health Home/IE that notifies the applicant/participant of an action taken by the waiver program, including an explanation of the reasons for the action. Notices of Determination/Decision (NOD) are issued when an applicant has been approved or denied acceptance into the waiver, or if the participant is being discontinued. The Health Home/IE must give the waiver applicant/participant adequate and timely notice when approving or denying waiver applications and/or when terminating a waiver participant's benefits. The Health Home/IE sends a written NOD to the participant. Participants are informed of their fair hearing rights in the NOD that is mailed to the participant.

Individuals in receipt of a NOD for eligibility issues related to the Children's waiver are eligible for an Informal Conference and/or a Fair Hearing. Children's applicants and participants have Fair Hearing rights under 18 NYCRR §358-3.1(b)(6). The regulation for the opportunity for a fair hearing is found in: 18 NYCRR 358-3.1 and for managed care, at 18 NYCRR 360-10.8.

Plan of Care Services
In addition to the required notices for eligibility, the HHCM/IEIE will exercise due diligence in advising participants about changes in the participant's Plan of Care, providers, available services and method of service delivery. A NOD is issued by the MCO or NYSDOH if a request for services are denied or limited or if existing services are terminated or limited (reduction) by the MCO or the NYSDOH. Participants of the waiver can request a State Fair Hearing at any time if they feel that the services which they are receiving are not adequate. Fair Hearing requirements require the entity providing the decision (e.g., MCO, NYSDOH, or Health Home/IE) to provide applicants/participants with timely and adequate notice of Fair Hearing rights when benefits under the waiver are denied, discontinued, or reduced.

Timely and adequate means that the effective date of the adverse action is 10 days after the date the notice was issued. If the individual is enrolled in managed care, the MCO will issue timely and adequate notice when terminating or limiting a waiver participant's benefits. This enables the individual time to exercise the MCO appeal (if enrolled) and State fair hearing rights. The Notice of Determination/Decision form includes instruction as to how to exercise the right to a managed care appeal, or if in FFS, an Informal Conference, as applicable, and State fair hearing.

A member enrolled in managed care must exhaust a plan appeal only where a plan made a decision to deny services. If the member is disputing the level of authorized care, the member can request more services. If the plan denies the increase request, then there is an MCO decision to appeal. If there was never a plan decision (i.e., an eligibility decision or prior to a utilization review decision by the MCO), the member can file State Fair Hearing at any time if they think their Medicaid benefits have been limited or delayed.

The NOD is sent if there is a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or for an enrollee in receipt of HCBS services and support, if there is a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports for a subsequent authorization period of such services. A participant/legal guardian does not generally have a right to Aid Continuing for concurrent review determinations for extended services beyond the original authorization period unless the above circumstances exist. The NYDOH or MCO must still provide Aid Continuing if so directed by the Office of Administrative Hearings. When the appeal or fair hearing is adverse to the enrollee, enrollees may be held liable for the cost of services they received during the appeal or fair hearing review as provided by 42 CFR 438.420(d). NYDOH or MCOs will not attempt to recoup such costs after an upheld Plan appeal until after the enrollee fails to request a fair hearing within 10 days of the Final Adverse Determination, or, for enrollees requesting a fair hearing, until after the adverse fair hearing decision. Participants are informed of their fair hearing rights in the NOD that is mailed to the participant. Participants are informed of their right to continuation of benefits in the NOD that is mailed to the participant.

Once a NOD is issued for a termination or reduction of existing services, the HHCM/IEIE is responsible to ensure the

participant/legal guardian understands their his/her right to file an appeal (for managed care members) or informal conference/fair hearing (for FFS participants) within ten days of the decision in order to be eligible for Aid Continuing. “Aid Continuing” means a participant has a right to the continuation of their already existing benefits until the appeal or fair hearing process is completed and a decision is rendered. If the request for appeal/fair hearing is not completed in the ten days window, the participant/legal guardians have 60 days from the notice date to request an appeal/fair hearing, but will not receive Aid Continuing. Managed care enrollees have 120 days to request a State fair hearing from the MCO appeal determination.

HHCM/IEIE/NYSDOH or its designee may assist the participant/legal guardian in filing appeals and Fair Hearing requests to prepare for and to provide any needed documentation on record to support the participant’s case to the Administrative Law Judge at the hearing. However, the HHCM/IEIE may not present evidence and/or a position at a fair hearing for the participant/legal guardian. The Health Home, MCO, or IE serves as the representing agent for NYSDOH at fair hearings.

The HHCM/IEIE is also responsible for explaining to the participant that when an appeal/fair hearing and Aid to Continue is requested, services remain in place until appeal/fair hearing disposition. The participant’s MCO will provide information relating to appeals per 42 CFR 438 subpart F and the State’s contract with the MCO. A copy of the fair hearing request and scheduling information is sent from Office of Temporary Disability Assistance (OTDA), which is responsible for managing and overseeing Fair Hearings for Medicaid issues, to the Health Home/MCO/IE, as applicable, and the participant.

To assure statewide uniformity, NYSDOH has advised the Health Home/ MCO /IE about appeals and fair hearing procedures and related official forms in the Health Home/MCO/IE contracts.

A copy of the NOD and Fair Hearing information is kept in the participant’s records maintained by Health Home/MCO/IE and the Care Manager.

MCOs/HH/IEs must separately track and report complaints, grievances, appeals, and denials related to the children’s populations and services covered including Children’s HCBS services under this waiver.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

New York State Public Health Law Article 49 provides a right to external appeal by an independent reviewer at no cost to Medicaid recipients, when an MCO denies a service request due to lack of medical necessity or as experimental/investigational. The New York State Department of Financial Services operates the external appeal process. Upon receipt of an initial adverse determination, if a delay will cause harm to the enrollee, the enrollee may request an expedited external appeal at the same time as an expedited internal plan appeal; if the matter is not eligible for expedited review, the enrollee may request an internal plan appeal, and upon receipt of an adverse appeal determination, has 4 months to request an external appeal. The enrollee and the plan may jointly agree to waive the internal plan appeal process and go directly to external appeal. The MCO's contract with the state describes the MCO's responsibility to inform enrollees of when they have the right to external appeal and how to exercise that right.; that these instructions are included in the NOD (initial adverse determination). An expedited external appeal is resolved in 72 hours or the request; a standard external appeal is resolved in 30 days with a possible extension of up to 5 business days for review of additional information . There is no impact on the enrollee's right to a State Fair Hearing. Once the enrollee has exhausted the MCO's internal appeal process, the enrollee has 120 days to request a State fair hearing. If the enrollee requests both an external appeal and a State fair hearing, the State fair hearing decision supersedes the external appeal decision. The participant is informed of their right to an alternative dispute resolution mechanism and that the dispute resolution mechanism is not a pre-requisite or substitute for a Fair Hearing in the NOD mailed to the participant and when applying for the alternative dispute resolution.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The NYS Department of Health Office of Health Insurance Programs /Division of Health Plan Contracting and Oversight. The Medicaid agency oversees this process through the IMT meeting process.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125). The OHIP Division of Health Plan Contracting and Oversight operates a complaint system that accepts complaints from enrollees, their designees and providers regarding the access to and quality of care received from an MCO consistent with federal definitions and timelines at 42 CFR 438 subpart F. These complaints are investigated and if an MCO deficiency or concern is identified, the MCO is required to implement a plan of correction. The MCOs are responsible for receiving, reporting, and responding to complaints received from enrollees. The MCOs are required to report the number and category of complaints filed with the MCO by Medicaid enrollees to the NYSDOH at least quarterly. All records including a summary of the grievance, the action taken by the MCO to address the grievance, the final disposition resolution, and dates of all actions are available to the NYSDOH upon request. The MCO's ability to receive and respond appropriately to complaints is reviewed at least every other year during the NYSDOH operational surveys, and more often if concerns are identified to ensure the effectiveness of the MCO's corrective action plan.

OHIP operates a Medicaid Help Line where participants may register complaints which are any expression of dissatisfaction other than an appeal. NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125) or managedcarecomplaint@health.ny.gov. The OHIP Division of Health Plan Contracting and Oversight operates a complaint system that accepts complaints from enrollees, their designees and providers regarding the access to and quality of care received. The HH/IE policies and procedures include how to manage and report complaints and incidents, and maintain supporting documentation related to the receipt and resolution of complaints and incidents (e.g., steps taken toward resolution, member satisfaction, etc.). HHs must have policies and procedures in place to identify problematic trends in agencies within their partner networks and provide appropriate interventions when corrective actions are needed. Actions must be taken to minimize the probability of recurrence. Such actions must be documented and available for review by the New York State Department of Health (NYSDOH). When a grievance cannot be resolved to the members satisfaction within 90 days the member may escalate complaints and grievances to the Medicaid Help Line or through their Managed Care Plans grievance and complaint procedure. Once resolved, HH/IE or NYSDOH will respond to the child/family by phone or in writing. The participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing when filing the grievance/complaint in the acknowledgement of the grievance mailed to the participant or on the call when the participant complains.

This report is reviewed during the IMT meeting in order to develop strategies for system improvement as needed. If significant concerns are identified, the NYSDOH or its designee will address an emergent issue regarding a specific provider or participant immediately.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ○ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ◉ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

The majority of children will be served by MCOs who are mandated to maintain critical incident identification, tracking and resolution processes. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum:
i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance;
ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

For Children in the FFS delivery system, there is a process in place for HHCM/IEIE to elicit information on the health and welfare of individuals served through the program and for reporting incidents of abuse, neglect, exploitation, or other concerns. At a minimum, the HHCM must maintain face to face contact with the waiver participant and his or her family consistent with the acuity of the child and the HH contact schedule. Contacts may occur in the child's home, school, or other appropriate location. The purpose of the contact is to provide ongoing support, advocacy and follow-up to assure appropriate service delivery for the child and family and serve as a vehicle to complete the six month review requirement for the waiver program. During these contacts, possible abuse, neglect, and exploitation may be identified, documented and referred to the appropriate entity for resolution. For children opting out of the HH, the IE and/or MCO will monitor during quarterly calls and POC reviews.
Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy.

Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

NYS has other supports in place, such as the statewide Child Abuse Hotline, to assist parents/guardians, teachers and social service workers report concerns for a child's health and safety.

The New York State Department of Health (the Department) is responsible for the oversight of the 1915(c) Children's waiver. OHIP staff will collate all reports of instances of incidents where there is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of a Children's waiver participant. This includes all reports from Health Homes and the IE and reports from the 1-800 number NYSDOH maintains to receive complaints (1-800-206-8125) or managedcarecomplaint@health.ny.gov. NYS has other supports in place, such as the statewide Child Abuse Hotline, to assist parents/guardians, teachers and social service workers report concerns for a child's health and safety.

All MCOs must provide a report of critical incidents identified and/or investigated by the Contractor involving Enrollees in receipt of long term services and supports. The report goes to SDOH on a quarterly basis, in a manner and format determined by SDOH,

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24

hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

For children opting out of the HH, the IE and/or MCO will monitor during semi-annual outreach and POC reviews. Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

The IEIE must report any health and welfare concerns to DOH on a quarterly and annual basis. The Department will review the incident reported by the IE and make recommendations, if necessary, to ensure that the IE referred and investigated the incident as appropriate is appropriate and in compliance with established DOH Standards.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes the Independent Entity, MCO contracts and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the MCOs, Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data. NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the MCO/Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Appendix G-1-a Continued:
The OHIP managed care staff are responsible for the day-to-day operation and oversight of the Children's MC delivery system and are accordingly responsible for assessing the performance of the MCO waiver administration which includes the roles and responsibilities of Health Homes contracted by MCOs. The State's External Quality Review Organization will perform managed care reviews including calculation and/or validation of performance measures per federal requirements at 42 CFR 438 subpart E.

Health Home and IEs are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers and IE Independent Evaluators (IEIE) and MCOs will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes, MCOs and the IE are responsible for investigating and responding to complaints and incidents that are received.

DOH staff receives a copy of complaint/incidents and conferences with the Health Home/IE to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home/IE/MCO and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home/MCO /IE and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home/MCO /IE staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home/MCO /IE staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125). The MCOs also have required under 438 Subpart F to maintain a complaint and Grievance system outlined in Appendix F of this document as well as the incident reporting required in 10.38 of the MCO contract.
See Appendix G-2-a for the remainder.

Appendix G-2-a Begins below:

The vast majority of children will be served by MCOs for acute care and HCB services who are mandated to maintain critical incident identification, tracking and resolution processes including restraints. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH.
All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

Waiver participants live at home or in the community primarily with their parent/legal guardian who have primary legal responsibility for their health and welfare. The HHCM are responsible for detecting unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during face to face contact performed according to the child's acuity and the HH contact schedule. The IE will monitor through quarterly calls and POC reviews. IEIEs, HHCM and HCBS providers are mandated reporters for child abuse to the

New York Statewide Central Register of Child Abuse and Maltreatment. The HHCM/IE takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

For children opting out of the HH, the IE and/or MCO will monitor during semi-annual outreach and POC reviews. Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.
The IEIE must report any health and welfare concerns to DOH on a quarterly and annual basis. The Department will review the incident reported by the IE and make recommendations, if necessary, to ensure that the IE referred and investigated the incident as appropriate is appropriate and in compliance with established DOH Standards.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes the Independent Entity and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the Independent Entity, and Health Homes to discuss FFS reports, fiscal

and program data and HCBS assurance data.

NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the
Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

Health Home and IEs are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers and IE Independent Evaluators (IEIE) will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes and the IE are responsible for investigating and responding to complaints and incidents that are received.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-2-a Continued begins Below:

DOH staff receives a copy of complaint/incidents and conferences with the Health Home/IE to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home/IE and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home /IE and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home /IE staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home /IE staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125).

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO and LDSS oversight as needed.
See Appendix G-2-b for the remainder.

Appendix G-2-b begins below:

Any staff person or family member who observes a use of restrictive intervention must report it immediately according to MCO critical incident reporting and agency protocol.

The vast majority of children will be served by MCOs for HCBS and acute care services who are mandated to maintain critical incident identification, tracking and resolution processes including identification of use of restrictive interventions. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH.
All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

Waiver participants live at home or in the community primarily with their parent/legal guardian who have primary legal responsibility for their health and welfare. The HHCM are responsible for detecting unauthorized use of restrictive interventions through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during face to face contact performed according to the child's acuity and the HH contact schedule. The IE will monitor through quarterly calls and POC reviews. IEIEs, HHCM and HCBS providers are mandated reporters for child abuse to the New York Statewide Central Register of Child Abuse and Maltreatment. The HHCM/IE takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions.

NYSDOH is responsible for oversight through HH and IE annual reviews. The New York State Department of

Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

For children opting out of the HH, the IE and/or MCO will monitor during semi-annual outreach and POC reviews. Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

The IEIE must report any health and welfare concerns to DOH on a quarterly and annual basis. The Department will review the incident reported by the IE and make recommendations, if necessary, to ensure that the IE referred and investigated the incident as appropriate is appropriate and in compliance with established DOH Standards.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes the Independent Entity and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data.

NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the

Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

Health Home and IEs are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers and IE Independent Evaluators (IEIE) will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes and the IE are responsible for investigating and responding to complaints and incidents that are received.

DOH staff receives a copy of complaint/incidents and conferences with the Health Home/IE to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home/IE and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home /IE and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home /IE staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home /IE staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125).

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met. DOH and the Interagency Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO and LDSS oversight as needed.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on*

restraints.)

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The vast majority of children will be served by MCOs for acute care and HCBS who are mandated to maintain critical incident identification, tracking and resolution processes including use of seclusion. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS services under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH.

All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire.

Waiver participants live at home or in the community primarily with their parent/legal guardian who have primary legal responsibility for their health and welfare. The HHCM are responsible for detecting unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaints/grievances or incident reporting. The HHCM are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare. HHCM regularly monitor participant health and welfare during face to face contact performed according to the child's acuity and the HH contact schedule. The IE will monitor through quarterly calls and POC reviews. IEIEs, HHCM and HCBS providers are mandated reporters for child abuse to the New York Statewide Central Register of Child Abuse and Maltreatment. The HHCM/IE takes reports about use of restraint or seclusion from parents or other staff and reports to New York Statewide Central Register of Child Abuse and Maltreatment. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all of the professionals involved in a member´s care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders), and social service needs are addressed in a comprehensive manner. A reportable incident is an event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Health Home policies and procedures must mandate that the CM inform the HH of a reportable incident within 24 hours of notification or discovery (or where applicable, by the next business day), including the known facts and circumstances of the incident, the member's enrollment date, last contact date and type, and current location, if known. The following is a list of reportable incidents.
1. Allegation of abuse, including • Physical abuse • Psychological abuse • Sexual abuse/sexual contact • Neglect • Misappropriation of member funds
2. Suicide attempt
3. Death
4. Crime Level 1
5. Missing person
6. Violation of Protected Health Information (PHI)

The HH must inform the Department within 24 hours of notification from the CM (or where applicable, by the next business day), any reportable incident listed above, along with initial findings. At a minimum, the HH must immediately review the facts and circumstances of the current incident with the CM, along with all pertinent information and incident reports. The HH will provide oversight and direction to the CM to ensure member safety and well-being as well as program integrity, overall programmatic expectations, and compliance with Health Home Standards.

The Department will review the incident reported by the HH and make recommendations, if necessary, to ensure that the Health Home's reportable incident policy is appropriate and in compliance with established HH Standards. The Department will require HHs to submit, on a quarterly basis, the total number of reports in each of the

categories noted on the Health Home Reportable Incident Form, due by the 10th business day after the end of the quarter: • January – March, due April; • April – June, due July; • July – September, due October; and • October – December, due January.

For children opting out of the HH, the IE and/or MCO will monitor during semi-annual outreach and POC reviews. Note: the use of telehealth meeting HIPAA privacy requirements (Health Insurance Portability and Accountability Act of 1996) may be utilized for care management to monitor health and welfare as provided for in statute, State regulations and policy. Waiver participants reside in the community or the home of the parent/guardian, who has legal responsibility for them, and attend school or other public activities where legally mandated reporters and/or other concerned persons can notice and report possible issues regarding a participant's care. For instance, under section 413 of the NYS Social Service Law, nurses are named as mandated reporters who have a legal obligation to report abuse or neglect. Enactment of "Xctasy's Law" includes Local Department Social Service (LDSS) workers as legally mandated reporters.

The IEIE must report any health and welfare concerns to DOH on a quarterly and annual basis. The Department will review the incident reported by the IE and make recommendations, if necessary, to ensure that the IE referred and investigated the incident as appropriate is appropriate and in compliance with established DOH Standards.

The OHIP is responsible for the day-to-day operation and oversight of the Children's FFS and managed care delivery system. This includes the Independent Entity and oversight of Health Home program, including standards requirements and roles and responsibilities.

DOH OHIP in conjunction with other DOH divisions assesses the performance of the contractors participation in a variety of ways. The summary of DOH findings from program assessment activities are provided in the annual 372 narrative. DOH has regular meetings with the Independent Entity, and Health Homes to discuss FFS reports, fiscal and program data and HCBS assurance data.

NYSDOH OHIP staff oversee and monitor the administration of the Children's waiver through annual case record reviews designed to assess the
Health Home/Independent Entity understanding of its role and responsibilities, and waiver administrative processes. Once the applicant is enrolled in the Children's waiver, NYSDOH staff oversees and monitors the administration of the Children's waiver through annual case record reviews designed to assess the waiver functions.

Health Home and IEs are also required to submit summaries of reported participant complaints or dissatisfaction with services or providers of services in addition to incidents such as reportable incidents. These reports and records are used to assess waiver administrative performance. Health Home Care Managers and IE Independent Evaluators (IEIE) will track and trend complaints/grievances and reportable incidents received and resolve those issues consistent with contractual requirements and federal regulations. This process is ongoing, not limited to quarterly reports made to NYSDOH. Health Homes and the IE are responsible for investigating and responding to complaints and incidents that are received.

DOH staff receives a copy of complaint/incidents and conferences with the Health Home/IE to ensure proper investigation is done according to established procedures. NYSDOH staff will hold conference calls with the Health Home/IE and the complainant if NYSDOH staff determines that the situation warrants it. NYSDOH staff participate in a variety of activities to provide technical assistance in order to maintain an open line of communication with the Health Home /IE and investigate complaints/incidents. For example, quarterly conference call meetings with the Health Home /IE staff statewide, provide opportunities for information updates and discussion of issues to ensure consistency in policy interpretation and implementation. Minutes of the meetings are sent to all Health Home /IE staff. NYSDOH staff participate in training and other meetings such as the statewide Health Home meetings. These meetings provide an opportunity for information and feedback about administrative issues, encourage discussion of common concerns and interests, and development of corrective activities that directly impact the Children's waiver.

NYSDOH maintains a 1-800 number to receive complaints (1-800-206-8125).

Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's services agencies will collect the reports outlined in the waiver application and review at least quarterly to ensure that the specialized needs of various populations included within the Children's waiver are met. DOH and the Interagency

Monitoring Team will review issues as outlined in Appendix H as well as providing DDRO and LDSS oversight as needed.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver participants in Foster Care living in homes (foster homes, kinship homes or their own homes) must be monitored regarding their ability to self-administer medications. Upon admission into the waiver, every six months and as necessary, the foster care worker gathers information regarding the child's ability to self-administer medications. If problems are identified, the child and family/caregiver are referred to an appropriate service provider for an assessment and/or training and assistance so that safe management of the child's medication will occur. An appropriate service provider may include providers of Medicaid State Plan services, other local, State or Federal program providers or a waiver services provider. In some instances, informal supports may be utilized. All waiver staff is responsible for reporting cognitive, physical and/or behavioral changes to the foster care worker which may require intervention. Children residing in foster boarding homes are under the supervision of trained foster parents. These parents provide routine care to children, including medication administration.

Each child in an agency operated boarding home (AOBH) or group home setting must have an Individual Medication Plan (IMP) maintained in the child's medical record and accessible to staff who administer medication to that child. The IMP is developed at the initial comprehensive health assessment by a licensed medical practitioner and reviewed and updated at least annually and whenever there is a change. The IMP shall include the condition or diagnosis for which a prescribed or over-the-counter medication is to be used, medication name, dosage and route of administration, the frequency of administration, monitoring standards for each medication, the child's capability to self-administer medication, and specific instructions related to the medication. An individual Medication Administration Record (MAR) will also be maintained in the child's medical record and made accessible to staff who administer medication to that child. The MAR must include the date and time that each dose is administered and the initials of the individual who administered, assisted or supervised the self-administration of the medication. The MAR must also include documentation of medication errors, actions taken, and effects of the errors.

A determination must be made for each child receiving medication in an AOBH or group home as to the child's ability to self-administer medication. The determination of the child's ability to self-administer medication is made by the prescribing physician in conjunction with the child's treatment team. Any such determination must be documented in the child's medical record.

All authorized agencies that provide AOBH or group home care for children in foster care must use the services of a licensed medical practitioner to oversee all aspects of medication administration in those settings. These include but are not limited to: reviewing the prescribing practitioner's medication orders; reviewing medications received from pharmacies for accuracy and compliance with orders; reviewing medication administration records for accuracy, timeliness, and compliance with orders; working with trained staff in the administration of medication to children; directing the storage and handling of medication in accordance with applicable statutes; reviewing the content and provision of medication training for agency staff; and overseeing the maintenance of each child's IMP and MAR.

During the time frame that a child is in foster care, second-line monitoring is provided by the LDSS' case manager, at minimum, every six (6) months at Service Plan Reviews and the voluntary agency's case planner on a more frequent, routine basis, tailored to the individual child. Second-line monitoring detects potentially harmful practices through observation of the child and dialogue with the child's caregivers. When concerns are identified, the prescribing medical professionals engage in determining further action to be taken. As needed, additional training is provided to the child and the child's caregivers, as appropriate.

The Individual Medication Plan is monitored at least annually and whenever there is an update/ change or new prescribing practitioner's medication order. In addition the Individual Medication Plan is monitored by a licensed medical practitioner and would include behavior modifying medications.

The foster care worker and the HHCM works with medical providers to ensure open communication regarding any changes/needs in the child's behaviors.

Second-line monitoring is conducted in the same way for all medication including behavior modifying medications.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that

participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

AOBHs and group homes are licensed and monitored by OCFS who is ultimately each child's guardian. OCFS has specific regulations to file regarding medication management and medication assistance for children in AOBHs and group homes. These regulations require that child caring agencies must have written policies and procedures to address the safe and effective administration of medication and require OCFS to review and approve each agency's policies. Policies must address: communication, documentation, and staffing requirements for safe and effective medication management; procedures for medication administration when the child is offsite, including home visits and school; procedures and safeguards for the use of 'as needed' and over- the-counter medications; procedures and safeguards to prevent medication errors; a plan for training staff involved in administering, assisting and supervising the self-administration of medication. Training includes written and skills competency tests, and annual updates. OCFS conducts periodic reviews, at a minimum once every three years, of agencies that include an evaluation of compliance with the policies for administration of medication.

All authorized agencies that provide agency operated boarding home or group home care for children in foster care must use the services of a licensed medical practitioner to oversee all aspects of medication administration in those settings. These include but are not limited to: reviewing the prescribing practitioner's medication orders; reviewing medications received from pharmacies for accuracy and compliance with orders; reviewing medication administration records for accuracy, timeliness, and compliance with orders; working with trained staff in the administration of medication to children; directing the storage and handling of medication in accordance with applicable statutes; reviewing the content and provision of medication training for agency staff; and overseeing the maintenance of each child's Individual Medication Plan and Medication Administration Record.

OCFS is the state agency responsible for direct oversight of Agency Operated Boarding Homes (AOBHs) and group homes. OCFS monitors the AOBHs and group homes and is ultimately each child's guardian.

However, DOH is the State agency responsible for licensing these types of facilities under 29i authority. (Article 29-I of Section 1 of the Public Health Law Section 2999-gg. Voluntary foster care agency health facilities.) DOH has the authority to bring enforcement actions against facilities based on failure to comply with applicable laws and/or regulations following a survey or the investigation of an incident or complaint. Enforcement actions include revocation, suspension, limiting, annulling, or denial of a licensed of an authorized agency to provide limited health-related services or of any imposition of a civil penalty against such entity. DOH and OCFS have a memorandum of understanding regarding the provision of services under 29i.

OCFS is required through the MOU with DOH to notify DOH immediately of any situations in which OCFS suspects a provider's alleged noncompliance a requirement caused harm or may have the potential for placing patients in harm upon having knowledge of such harm or in situations. This includes notification of the DOH Office of Professional Medical Conduct, Office of the Medicaid Inspector General or the State Education Department Office of the Professions of any 29i licensee that OCFS believes may be in non-compliance with laws and/or regulations. The OCFS must also notify DOH of findings relating from any investigations carried out by OCFS on DOH's behalf due to complaints and making recommendations to DOH regarding enforcement actions to be taken by DOH. OCFS must also notify DOH of its intent to limit, revoke or suspend approval of an authorized agency to operate a foster care program or an operating certificate of a facility caring for foster care that may impact the 29i certificate of a facility and of the surrender of an operating certificate by an authorized agency. OCFS must notify DOH if it intends to assign responsibilities to another contractor.

OCFS conducts on-site inspections of authorized agencies that have applied to become licensed by the DOH to provide limited health-related services in accordance with the process and monitoring tools developed by OCFS and approved by DOH with the technical assistance of DOH as needed. OCFS investigates complaints/incidents in accordance with accordance with the process and monitoring tools developed by OCFS and approved by DOH with the technical assistance of DOH as needed. On-site inspections occur every three years or when a complaint/incident is received.

The MOU outlines that OCFS and DOH will share surveillance information, including but not limited to, survey findings, complaint allegations and incident reports, such that DOH may provide the technical assistance and enforcement action obligation.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- (●) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
  Do not complete the rest of this section

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed

and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of appeals/state fair hearings filed by participants that were resolved according to approved waiver guidelines. (percentage = timely resolved appeals and state fair hearings/total appeals and state fair hearings)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95%
☒ **Other** Specify: HH,MCO, IE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH,MCO, IE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Percent of participants who received information on how to report suspected abuse, neglect, or exploitation, or unexplained death (percentage = number of participants receiving waiver information/total number of waiver participants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH,MCO, IE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH,MCO, IE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of reports related to abuse, neglect, and exploitation and unexplained death of participants where an investigation was initiated within the established timelines (percentage = timely investigations referred and/or initiated in a timely manner/total reports)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

HH,MCO, IE		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of substantiated cases of abuse, neglect and exploitation and unexplained death where recommended actions to protect health and welfare were implemented (percentage = cases of abuse, neglect and exploitation and unexplained death with recommendations where actions were implemented actions /total cases)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HH,MCO, IE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
HH,MCO, IE	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of FFS waiver participants enrolled in HH who have face to face contact with HHCM consistent with the participant's Health Home acuity level (percentage = FFS waiver participants enrolled in HH who have face to face contact with HHCM consistent with the participant's Health Home acuity level/total FFS participants enrolled in HH).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95
☒ **Other** Specify: HH	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: HH	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of systemic interventions implemented from the recommended interventions based on incident trends from quarterly IMT meetings (percentage = system interventions implemented/systemic interventions recommended)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95
☒ **Other** Specify: IMT meeting minutes	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Percent of MCOs that are maintaining critical incident identification, tracking and resolution processes (percentage = MCOs maintaining critical incident identification, tracking and resolution processes/total MCOs)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: State Medicaid Agency and MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant incidents that were reported, reviewed, and completed within required timeframes as specified in the approved waiver (percentage = incidents with timely response/total incidents)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO critical incidents database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: HH, MCO, IE, or EQRO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
MCO, HH, IE, or EQRO	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unauthorized uses of restrictive interventions including restraints and seclusion that were appropriately reported (percentage = restrictive interventions appropriately reported/total restrictive interventions)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO critical incident/restrictive intervention database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: MCO or EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: MCO or EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of HCBS participants who received annual physical exams (percentage = number of participants with annual physical exams/total participants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO encounter data and eMedNY claims

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO or EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: MCO or EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Note for Sub-assurance a: OHIP within DOH aggregates the reports for all of the performance measures below from all sources in order to calculate the overall PMs for both the FFS and MCO delivery system. The reporting includes:
1. The statewide State Fair Hearing appeals for waiver participants both in FFS or MC,
2. All MCO reports of appeals of waiver participants
3. The NYSDOH case file reviews for both FFS and MC that validated the participants who received information on how to report suspected abuse, neglect, or exploitation, or unexplained death
4. MCO and FFS reports related to abuse, neglect, and exploitation and unexplained death of participants where an investigation was initiated within the established timelines, and
5. MCO and FFS cases of abuse, neglect and exploitation and unexplained death where recommended actions to protect health and welfare were implemented

The vast majority of children will be served by MCOs providing acute care services and HCBS and who are mandated to maintain critical incident identification, tracking and resolution processes including identification of use of seclusion, restraint and restrictive interventions. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS under this waiver.
See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire

The protection of waiver participants' health and welfare begins with the HHCM and IE/MCO and at the local level with the LDSS Child Protective Services Unit (CPS). HCBS providers and HHCM and licensed practitioners in the IE are mandated reporters for child abuse under NY state law. The New York State Office of Children and Family Services maintains a New York Statewide Central Register of Child Abuse and Maltreatment for reports made pursuant to New York State Social Services Law. If the call is accepted, the LDSS Child Protective Services staff investigates and takes any necessary actions to protect children from further abuse or maltreatment, and to provide rehabilitative services to children, parents, and other family members.

The HHCM contacts the waiver participant's family at a minimum, on a basis consistent with the participant's acuity and the HH contact schedule. The contact may occur in the child's home or at another location such as the child's school. The purpose of the contact is to provide ongoing support, advocacy, and follow-up for the child and family, including identifying possible abuse, neglect, or exploitation. If one of these problems is identified, it is then documented and referred to the appropriate entity.
These meetings also serve as a vehicle to complete the six month assessment requirement for the waiver program. For children who opt out of HH, the IEIE/MCO will monitor through quarterly calls and POC reviews (the MCO will monitor the State plan service delivery under their contracts).

NYSDOH staff routinely discuss efforts to prevent abuse, neglect, and exploitation with the HH, MCOs and IE during quarterly statewide conference calls. The aim is to develop enhanced and consistent statewide incident reporting and documentation processes. NYSDOH staff also work with the staff of the HH/MCO/ IEs to provide waiver participants and their parents/legal guardians with information about mandated incident reporting policies.

Finally NYSDOH, MCO, HH, or IE staff performs an annual statistically significant case record review and evaluation. If any patterns of error are identified, or greater than fifteen percent of reviewed cases are found to be "unsatisfactory", the NYSDOH will take action in the form of further inquiry, assessment of a need for training and/or further evaluation of the Children's administrative system (including the protocol and performance of the care manager). These systemic measures have the underlying purpose of preventing abuse, neglect and

exploitation of those in the Children's waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The remediation process is initiated when the MCO/HH/IE or NYSDOH staff or Interagency Monitoring Team identifies health and welfare issue with a child. The vast majority of children will be served by MCOs who are mandated to maintain critical incident identification, tracking and resolution processes. See contract standard 10.38. In the children's plan standards requirements, MCOs are required to separately track critical incident reporting related to children's populations and service covered for children including HCBS under this waiver. See contract standard 10.38. The MCO must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its Enrollees in receipt of Long Term Services and Supports on a continuous basis. Such mechanisms will include, at a minimum: i) A process to include information in education materials distributed to Enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for Enrollee assistance; ii) provisions in subcontracts to ensure providers of long term services and supports comply with State requirements for worker criminal background checks; iii) identification of critical incidents, including but not limited to: wrongful death, restraints, and medication errors resulting in injury, which are brought to the MCO's attention, and subsequent investigation or referral of the incidents to oversight agencies; and iv) reporting critical incidents to NYSDOH. All MCO clinical staff must be trained on reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care) within 30 days of hire. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

In such situations, the standard procedure is for NYSDOH staff, MCO, and Interagency Monitoring Team, to discuss the situation and for NYSDOH to issue a statement of deficiency(ies). The HH or IE must provide a plan of correction and address any issues at the child/family level. NYSDOH staff, MCO and the IMT may collaboratively work with the HH or IE to develop a plan of correction, if necessary. Implementation of and compliance with the plan of correction are monitored by NYSDOH and MCO.

If the plan of correction requires a change in the participant's service, NYSDOH staff and the MCO will work cooperatively to address the service deficiency and when necessary, transition the child to another waiver provider. The HHCM or IEIE will communicate any changes needed to the family and help the family find alternative providers. To ensure continuity of service during the transition period, the original provider will be required to transfer the participant case records and other pertinent documents to the new provider until transition is complete.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide waiver services. The provider may be referred to the licensure or certification agency staff, as needed. Accordingly, NYSDOH staff, or its designee the IMT, will issue a letter to the provider terminating the provider's waiver designation provider status.

Unsatisfactory accessibility modification and adaptive and assistive equipment contractors will be notified of their disqualification from further service by the administering LDSS/DDRO/MCO. The HHCM, MCOCC, or IEIE will help the family find alternate contractors.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO/IE staff, the CM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families documented by MCO, IE and HH; and the results of NYSDOH annual reviews. All such documents are maintained in the participant's case file. Circumstances involving remediation are maintained, as appropriate, by NYSDOH and/or the MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Interagency Monitoring Team (IMT) is chaired by NYSDOH staff with representation from State children's licensing, certification, designation and service agencies (OMH, OASAS, OCFS and OPWDD) and collects the reports outlined in the waiver application with review at least quarterly. An interagency agreement outlines oversight roles of IMT partners. NYSDOH and the IMT committee holds the primary responsibility for monitoring and assessing the effectiveness of system and programmatic design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from participants, stakeholders, providers, MCOs, and Health Homes/IE. At IMT meetings, IMT members:
-Track and trend aggregated data and review data including all HCBS performance measures,
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of any corrective action plans associated with the administration of the Children's waiver,
-Discuss any provider designation issues, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities.

NYSDOH and the IMT meet with the MCOs, HH,s or IE to discuss any identified issues or concerns.

Typically, NYSDOH, in collaboration with the NYS licensing and certification agencies on the IMT, implements system design change to MA waiver programs when there is a clear and strong need has been identified by State and/or local waiver staff or other stakeholders.

Stakeholders have several vehicles with which to voice their concerns, including regional meetings, stakeholder surveys, contact with their Care managers, HCBS providers, MCOs, IE and direct communication with NYSDOH waiver management staff or its designee the IMT. If monitoring review substantiates that a particular issue needs to be addressed, remediation actions are taken. Should the agreed upon remedies not be a satisfactory resolution, further study of the particular waiver element is undertaken. The recommendations of NYSDOH waiver management staff, IMT, HH/MCO/IE, waiver participants, providers and other stakeholders are considered.

Position papers summarizing the findings and analysis are presented to senior NYSDOH managers and its designee the IMT. Recommendations are prioritized by NYSDOH in consultation with the State Medicaid Director and State agency partners on the basis of the scope of the policy, its impact on waiver participants, and the overall ability of the State to accommodate any fiscal impact.

Subsequent recommendations are approved in keeping with programmatic priorities, consumer benefit, and the opportunity for administrative efficiency and system wide reform.

If the system change is accepted but cannot be made administratively, certain measures are recommended and implemented though the established annual NYS budget and legislative process. At this stage, NYSDOH staff, in collaboration with other state agency partners, brief NYS Division of the Budget and Legislative staff, and discuss the proposals with program participants, advocates, providers, and other stakeholders to gain their input and support.

NYSDOH staff and its designee, the IMT, implement system change when authorized by NYSDOH and the Medicaid Director. All MCOs must comply with the provisions in their contracts regarding Quality Assurance and reporting to the state. Each MCO may be required, at the State's option, to conduct an internal performance improvement project (PIP) on a topic affecting the children's populations. Each MCO will separately track, trend, and report complaints, grievances, appeals, and denials related to the children's populations and services including HCBS. For children eligible for HCBS, each MCO's UM BH subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:

i. Use of crisis diversion and crisis intervention services;
ii. Prior authorization/denial and notices of action;
iii. HCBS utilization;
iv. HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and
v. Enrollment in Health Home.

The foundation of the Children's waiver QIS is built upon discovery through performance metrics, reporting to stakeholders, and systems wide analysis and collaboration that leads to effective remediation strategies, quality of care enhancements, and ultimately mission-driven progress. The DOH construct establishes a series of offices within OHIP that interface with stakeholders and create a framework to develop, monitor and revise quality improvement initiatives throughout the Children's service system in New York State.

DOH leadership will establish priorities for the Children's waiver. OHIP within DOH will guide the system, identify critical areas for improvement, coordinate new and ongoing efforts, and develop strategies to make sure that the system is person-centered and sustainable. OHIP will focus on: transitioning to managed care; achieving transformation goals; and continuing to work with the provider community to find efficiencies and foster innovation.

The Interagency Monitoring Team (IMT) is chaired by NYSDOH staff with representation from State children's licensing, certification, designation and service agencies (OMH, OASAS, OCFS and OPWDD) and collects the reports outlined in the waiver application with review at least quarterly. An interagency agreement outlines oversight roles of IMT partners. NYSDOH and the IMT committee holds the primary responsibility for monitoring and assessing the effectiveness of system and programmatic design changes to determine if the desired effect has been achieved. These meetings review findings, make recommendations for strategies and assess the effectiveness of system improvements on a quarterly basis.

This includes incorporation of feedback from participants, stakeholders, providers, and Health Homes/MCOs/IE. At IMT meetings, IMT members:
-Track and trend aggregated data and review data including all HCBS performance measures,
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of any corrective action plans associated with the administration of the Children's waiver,
-Discuss any provider designation issues, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities.

NYSDOH and the IMT meet with the HHs or IE to discuss any identified issues or concerns using regularly scheduled monthly and quarterly meetings.

Typically, NYSDOH, in collaboration with the NYS licensing and certification agencies on the IMT, implements system design change to MA waiver programs when there is a clear and strong need has been identified by State and/or local waiver staff or other stakeholders.

Stakeholders have several vehicles with which to voice their concerns, including regional meetings, stakeholder surveys, contact with their Care managers, HCBS providers, MCOs, IE, and direct communication with NYSDOH waiver management staff or its designee the IMT. If monitoring review substantiates that a particular issue needs to be addressed, remediation actions are taken. Should the agreed upon remedies not be a satisfactory resolution, further study of the particular waiver element is undertaken. The recommendations of NYSDOH waiver management staff, IMT, HH/MCO/IE, waiver participants, providers, and other stakeholders are considered.

Stakeholders will receive information regarding changes through the State's web-site, regularly scheduled quarterly and annual meetings with advocates, regional meetings, direct communication with NYSDOH waiver management staff and through direct mail to participants

Position papers summarizing the findings and analysis are presented to senior NYSDOH managers and its designee the IMT. Recommendations are prioritized by NYSDOH in consultation with the State Medicaid Director and State agency partners on the basis of the scope of the policy, its impact on waiver participants, and the overall ability of the State to accommodate any fiscal impact.

Subsequent recommendations are approved in keeping with programmatic priorities, consumer benefit, and the opportunity for administrative efficiency and system wide reform.

If the system change is accepted but cannot be made administratively, certain measures are recommended and implemented though the established annual NYS budget and legislative process. At this stage, NYSDOH staff, in collaboration with other state agency partners, brief NYS Division of the Budget and Legislative staff, and discuss the proposals with program participants, advocates, providers, and other stakeholders to gain their input and support.

NYSDOH staff and its designee, the IMT, implement system change when authorized by NYSDOH and the Medicaid Director. . All MCOs must comply with the provisions in their contracts regarding Quality Assurance and reporting to the state. Each MCO may be required, at the State's option, to conduct an internal performance improvement project (PIP) on a topic affecting the children's populations. Each MCO will separately track, trend, and report complaints, grievances, appeals, and denials related to the children's populations and services including HCBS. For children eligible for HCBS, each MCO's UM BH subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:

i. Use of crisis diversion and crisis intervention services;
ii. Prior authorization/denial and notices of action;
iii. HCBS utilization;
iv. HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and
v. Enrollment in Health Home.

The types of quality improvement reports that are compiled include the following
-Tracked and trended aggregated data and review data including all HCBS performance measures,
Data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Monitoring of any corrective action plans associated with the administration of the Children's waiver,
-Provider designation issues, and
-Quality assurance/quality improvement initiatives and activities.

The frequency with which such reports are compiled: Reports are compiled as specified in the HCBS Assurance measure or on a quarterly basis if not otherwise specified
Results are communicated, and with what frequency, to agencies, waiver providers, participants, families and other interested parties, and the public:
• The IMT at quarterly meetings.
• The MCOs, HHs or IE to discuss any identified issues or concerns using regularly scheduled monthly and quarterly meetings and established contractual communication channels.
• Participants, families and other interested parties and the public – through the State's web-site, regularly scheduled quarterly and annual meetings with advocates, and through direct mail to participants.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: HH and IE	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Oversight of the concurrent waivers is performed by an Interagency Monitoring Team (IMT), chaired by NYSDOH staff, with representation from State children's licensure, certification, designation and service agencies. An interagency agreement outlines oversight roles of IMT partners. NYSDOH, through the IMT committee holds the primary responsibility for monitoring and assessing the effectiveness of system and programmatic design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from participants, stakeholders, providers, MCOs and Health Homes/IE. At IMT meetings, which occur at least quarterly, IMT members:
-Track and trend aggregated data and review data including all HCBS performance measures
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of any corrective action plans associated with the administration of the Children's waiver, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities. NYSDOH and the IMT meets with the MCOs, HHs or IE to discuss any identified issues or concerns.

NYSDOH contracts with an EQRO, as required by federal managed care regulations, to evaluate the MCOs' compliance with the quality assurance standards outlined in the contract. Representatives of the IMT, in conjunction with the External Quality Review Organization (EQRO), also conduct an annual review of each MCO's operations. A written report of findings is generated and a plan of correction for deficiencies is implemented if needed annually.

For FFS specifically, the State collects, monitors, and analyzes feedback regarding system design changes using several different methods. The participant survey method is used to gauge the effectiveness of the waiver program by asking for the input of those who use the waiver's services. The HHCM, IEIE and NYSDOH with the IMT staff record and gather responses to system changes in the waiver by contacting and meeting with parents, advocate groups, providers and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement (QA/QI) strategies are reevaluated on an annual basis and whenever areas of improvement are identified. Post assessments of QA/QI initiatives are used to determine the effectiveness of the QA/QI initiatives and whether these new activities should become an ongoing part of the program and/or whether additional strategies are needed. The Quality Assurance Reporting Requirements (QARR) results and improvement strategies are posted on the DOH website.

The IMT reviews the Quality Improvement Strategy QIS and its deliverables on at least a semi-annual basis and will provide updates to CMS when appropriate. Evaluation of the QIS is the responsibility of the IMT and will take into account the following elements:
-Compliance with federal and state regulations and protocols
-Effectiveness of the strategy in improving care processes and outcomes
-Effectiveness of performance measures used for discovery
-Relevance of the strategy with current practices

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

HCBS are provided by Non-State Govt and Private provider agencies. Private provider agencies are non- profit organizations or proprietary agencies. Non-profit organizations include not-for profit corporations formed under the NYS Law or authorized to do business in NY.

NYSDOH is the single State agency responsible for monitoring payments made under the New York State Medicaid program.

Statewide audits of Medicaid funded programs are conducted by the Office of the State Comptroller (OSC), the Office of the Attorney General (AG), the Department of Health, and the Office of the Medicaid Inspector General. In addition, the operating agency and local counties also conduct reviews and audits of Medicaid funded programs.

Annual Fiscal Reporting and Auditing: Fiscal reporting for non-profit waiver services will be subject to review until the transition to managed care, NYSDOH will seek an amendment to the waiver implementing fiscal reporting using the CMS agreed-upon format. The fiscal report will be submitted to CMS within 16 months after the close of the reporting period.

Delinquent Fiscal Reporting for Non-State Providers: If a provider has not filed a complete and compliant annual fiscal report for any reporting period, the Provider will be considered delinquent. The State will not claim FFP for any Waiver Services provided by a delinquent provider.

For fiscal reporting for FFS providers and thereafter, NS providers are required to file an annual fiscal report to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. If a NS provider fails to file a complete and compliant fiscal report within 60 days following the imposition of the penalty outlined in State Penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the penalty; and the State will not claim FFP for any waiver services provided by the NS provider with a date of service after the 240 day period.

Oversight of Service Delivery and Billings and Claims: For children in FFS, each waiver year, NYSDOH will establish an audit pool that includes all waiver service providers with waiver service billings. Paid claims will be audited to ensure that providers are appropriately billing for authorized services, correct reimbursement rates/fees, and for the correct number of units of service. NYSDOH conducts an annual review of less than 100% of records of individuals actively enrolled in Children's waiver services at the time of audit using a statistically reliable sample with a 95% confidence interval and a 5% margin of error using Raosoft formulas.

The sample is garnered from paid claims data presented in eMedNY. In conjunction with this review, paid claims will be cross referenced to Care Plans to ensure billing is consistent with services in the approved plan. Audit protocols are applied to a specific provider type or category of service in the course of an audit. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. Effective for dates of service beginning with the approval of the waiver, all waiver providers are subject to audits.

Any systemic deficiencies will be identified and a plan of correction developed which may result in the following: new directives to providers, procedural remedy, specific vendor intervention (vendor hold and/or termination), or amendment to the waiver application. Improperly paid claims will be reimbursed to the state and FFP will be returned to CMS. Annual audits of claims shall be completed with 12 months following the end of the waiver year.

The HHCM and IEIE/MCOCC are in regular contact with the participant/parent/legal guardian to assess if services are being provided. Any discrepancies between the plan of care and actual delivered services are identified through a range of methods including retrospective reviews of the plans of care, a retrospective paid claims review, provider surveillance, and/or information received by the HHCM, IE, MCO and/or NYSDOH staff.

Random review of cases are conducted by comparing paid claims to services authorized in the plan of care and parents of the participant are asked to certify that certain waiver services were provided and completed in accordance with an approved agreement. Every waiver participant must have a recipient restriction/exception (R/E) code on his or her Medicaid enrollment file that identifies the child as a Children's waiver participant. The eligibility worker is responsible for putting the Children's R/E code and effective date on the participant's WMS file.

Under managed care, the MCO is non-risk for the first 2 years of the program operation for HCBS for children and will be at risk for HCBS after 2 years. New York anticipates that the MCO will take on risk for program operation for HCBS no earlier than year 5 of the waiver or at least two years after (10/1/21) the MCO began contractually performing operations for HCBS on a non-risk basis. The post-payment review process is described in Appendix I-2-d. The MCO conducts post pay reviews to validate that waiver services were in fact provided as billed. The financial integrity review is included in the MCO's fraud and abuse prevention and detection plan in compliance with managed care regulations at 42 CFR 438 Subpart H including requirements at 438.608(a)(1)(vii) and (5). This includes determining the accuracy of documentation, eligibility, services provided, and units billed. There are regular record reviews. MCOs may employ a variety of mechanisms to conduct post-payment reviews, as reported to the State at least annually in the MCO's fraud and abuse detection prevention plan, including some or all of the following, depending on each MCO's specific program integrity

design and size of the enrolled population: quarterly direct mailing to a statistically valid sample (95% confidence or greater) of enrollees who incurred medical claims to confirm if the service billed was provided; issuance of EOBs and encouraging enrollees to review billed services, and corresponding trained member services staff to respond to enrollee's inquiries regarding suspect EOBs; "secret shopper" programs; ongoing data mining utilizing advance software to conduct predictive analytics and statistical modeling to identify and assess patterns indicating fraudulent billing; "red flagging" providers with identified suspect activity for enhanced review and investigation; internal audits and internal controls to confirm claims are adjudicated based on provider fee schedules and appropriate coding; investigation of internal and external referrals indicating potential fraud or abuse; and quarterly and annual trend reports indicating activity that requires escalated review by senior officers of the MCO. When necessary based on identified issues from claims reviews, MCOs may review a significantly valid sample of medical chart records from providers for confirmation of services billed. More rarely, MCOs may also conduct on-site provider reviews, which may be conducted by contracted expert investigative companies. The MCO must verify actual service delivery against the EOB (claims processed) as outlined in the HCBS assurance PMs in Section D of this waiver. For children in managed care, Division of Health Plan Contracting and Oversight (DHPCO) staff meet monthly with the MCOs' administrators allowing for the review of financial reporting and budget items, as needed.

Disclosure of Financial Records and Processes: The MCO shall establish and maintain an accounting system in accordance with generally accepted accounting principles (GAAP). The MCO and any subcontractors shall make available to the State, its agents, and appropriate federal representatives, any financial records of the MCO or subcontractors. Accounting procedures, policies and records shall be completely open to State and federal audit at any time during the Contract Period and for six years thereafter.

Single Audit Act/Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (UAR): The 1915(c) operates concurrently with the 1115 waiver in the Mainstream Medicaid managed care program. DOH ensures the integrity of payments to managed care entities through provisions of the state's contract with managed care entities under the managed care regulations. Payments to MCOs are subject to ongoing fiscal accountability monitoring and reporting requirements to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver Under the managed care arrangements, the state does not make payments directly to waiver providers but instead makes PMPM payments to the managed care entities for the delivery of waiver services. The entities in turn pay individual providers, who are part of their networks, and are subject to contracting protections/reviews/member safeguards The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the MMMC program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. DOH will have oversight of all portions of the program and the MCO contracts, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through interagency monitoring, an important part of the overall state's Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the program – engaging program management, contract management, and financial management staff from DOH.
DOH to ensures financial accountability by ensuring that payments are only made to a managed care entity for eligible persons who have been properly enrolled in the waiver and through the External Quality Review process. The eMedNY system only pays for children that are eligible for Medicaid according to the rate schedule certified by the State's actuary and approved by CMS.

Independent Audits: The State of New York is required to secure an independent audit through an independent CPA as part of the Single Audit Act. The MCO, who manages the 1915(c) waiver services, must contract with and submit an annual independent audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance as a condition of the Medicaid provider agreement. The independent audit must comply with the Statement on Standards for Attestation Engagements (SSAE) SSAE No. 16 SOC 2 Type II requirements. The audit period must be 12 consecutive months with no breaks between subsequent audit periods. The MCO must submit copies of all certified financial statements and QARR validation audits by auditors independent of the Contractor to the SDOH within thirty (30) days of receipt by the Contractor. The due date for annual statements is April 1 following the report closing date. Quarterly Financial Statements and Staffing Data A) The MCOs submit Quarterly Financial Statements to SDOH. The due date for quarterly reports is forty-five (45) days after the end of the calendar quarter. DHPCO receives a copy of the annual audit. If there are any material issues, DHPCO staff asks the MCO for additional information. When a CPA does an audit, the CPA must determine if the entity is financially viable for the next fiscal year. If the CPA determines the entity is not financially viable, then the CPA must issue an ongoing concern opinion.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. ***Methods for Discovery: Financial Accountability Assurance:***
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. ***Sub-Assurances:***

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.***
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of providers who have payment recouped for waiver services due to a lack of proper supporting documentation. (percentage = providers with a lack of proper supporting documentation/total providers)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Routine Medicaid claims verification audits

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% CI*
☒ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

MCO		
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Percent of claims verified through the MCO or eMedNY compliance audit to have paid in accordance with the participant's waiver POC (percentage = claims verified/total claims reviewed)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Routine eMedNY claims verification audits; MCO compliance reports

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% CI*
☒ ***Other*** *Specify:* *MCO*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Percent of FFS claims paid using FFS rates that follow the rate methodology in the approved waiver application (Percentage = FFS claims paid using rates that follow the rate methodology in the approved waiver application/all FFS claims paid).

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
HCBS FFS fee schedule

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Percent of claims paid only for services rendered when participants were enrolled in the waiver and eligible for such services, and when the services were provided by a qualified provider. (percentage = claims paid for services only when participants was enrolled and eligible and provided by a qualified provider /total claims reviewed)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Routine eMedNY claims verification audits

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample***

		Confidence Interval = 95
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
NY pays MCOs a non-risk fee for HCBS services initially and actuarially sound rates

after two years. % of MCO HCBS payments consistent with the fee schedule initially and actuarially sound rates consistent with the approved waiver after two years (Percentage = MCO payments that are consistent with payment methodologies in the approved waiver /all MCO rates paid)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Payments to MCOs

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of claims in accordance with the waiver's approved rates. (percentage = claims paid in accordance with the waiver's approved rates /total claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Routine eMedNY claims verification audits

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%CI*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Appendix I-1 Financial Integrity and Accountability continued below:

Other Financial Reports: The MCOs submit financial reports, including certified annual financial statements, and made available documents relevant to its financial condition to SDOH and the State Insurance Department (SID) in a timely manner as required by State laws and regulations, including but not limited to PHL §§ 4403-a, 4404 and 4409, Title 10 NYCRR Part 98; and when applicable, SIL §§ 304, 305, 306, and 310. The SDOH may require the Contractor to submit such relevant financial reports and documents related to its financial condition.

For children in managed care, Division of Health Plan Contracting and Oversight (DHPCO) staff meet monthly with the MCOs' administrators allowing for the review of financial reporting and budget items, as needed. DHPCO will receive a copy of the annual audit. If there are any material issues, DHPCO staff will ask the MCO to provide additional information. When a CPA does an audit, one of the items they are required to do is determine if the entity is financially viable for the next fiscal year. If they determine that they are not financially viable, then they are required to issue an ongoing concern opinion.

Independent Audit:
Independent Audits: The MCO must submit copies of all certified financial statements and QARR validation audits by auditors independent of the Contractor to the SDOH within thirty (30) days of receipt by the Contractor.

The MCO is required to secure an independent financial audit .This is a condition of the Medicaid provider agreement. The State of New York is required to secure an independent audit through an independent CPA as part of the Single Audit Act.

The MCOs submit Annual Financial Statements to SDOH. The due date for annual statements shall be April 1 following the report closing date.

Quarterly Financial Statements and Staffing Data A) The MCOs submit Quarterly Financial Statements to SDOH. The due date for quarterly reports shall be forty-five (45) days after the end of the calendar quarter.

Other Financial Reports: The MCOs submit financial reports, including certified annual financial statements, and made available documents relevant to its financial condition to SDOH and the State Insurance Department (SID) in a timely manner as required by State laws and regulations, including but not limited to PHL §§ 4403-a, 4404 and 4409, Title 10 NYCRR Part 98; and when applicable, SIL §§ 304, 305, 306, and 310. The SDOH may require the Contractor to submit such relevant financial reports and documents related to its financial condition.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The remediation process is initiated when the MCO/IE or NYSDOH waiver management staff identifies a lack in the quality of provided services, or any other significant issue related to administration of the Children's waiver.

Remediation of financial issues begins immediately upon the discovery of any impropriety. NYSDOH waiver management staff, and other Department staff such as staff within the Fiscal Management Group (FMG), Provider enrollment and others, MCO and IE as appropriate, immediately initiate remediation of any inappropriate claims processed through eMedNY or through the MCO. Remediation may include voiding payments, adjusting paid claims, assigning penalties, and sanctioning providers through collaboration with OMIG and the Attorney General.

If the deficiency involves a service provider and implementation of the plan of correction does not sufficiently meet program requirements, the provider may be deemed unfit to continue to provide Children's waiver services. In such circumstances, NYSDOH waiver management staff will issue a letter to the provider terminating the provider's Children's waiver provider status.

Governmental entity or MCO secures a local vendor qualified to complete the required work for Accessibility and/or Adaptive and Assistive Equipment Vendors. Activities include and are not limited to determining the need for the service, the safety of the proposed equipment, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that vendors are qualified and that State required bidding procedures have been followed. Services are only billed to Medicaid or the MCO once the equipment is verified as received and the amount billed is equal to the contract value.

The Governmental Entity (for FFS enrollees) or the MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department's Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES- VR). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child, and the most cost effective approach to fulfill the child's need.

Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified and that State required bidding procedures have been followed. For Environmental Modifications, the governmental entity or MCO is the provider of record for billing purposes. Services are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value.
Home modifications are limited to individual or family owned or controlled homes. For FFS children receiving Environmental Modifications, Vehicle Modifications and Adaptive and Assistive Equipment Vendor, the Local Department of Social Services (LDSS) or DDRO claims these costs from the State. The Welfare Management System (WMS) is a mechanism for LDSS to report Medicaid expenditures to NYSDOH. These expenditures are authorized in WMS with a payment specific code and special claiming category for federal participation. Additional codes designate federally nonparticipating expenses and Non- Reimbursable expenses. The Governmental Entity and NYSDOH monitor this data. NYSDOH will advise the Governmental Entity of any inappropriate claims and the Governmental Entity staff will initiate remediation of the incorrect claim(s.)
An unsatisfactory Environmental or vehicle modification contractors will be notified that the contractor will be disqualified from further service by NYSDOH.

Documentation of remediation activities is accomplished by the following measures: correspondence among NYSDOH waiver management staff, MCO /IE staff, the HHCM, participants' and their parents/legal guardians, and/or service providers; amended plans of care; case reviews and reports of follow-up meetings with participants and their families; and the results of NYSDOH, IMT, and MCO annual reviews. All such documents are maintained in the participant's case file.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Children's waiver will operate effective April 1, 2019. The waiver will operate concurrently with the 1115 beginning October 1, 2019. This fee schedule expense reimbursement covers claims effective for dates of service beginning with the approval of the waiver.

Provider Reimbursement of Waiver Services -
Children's HCBS are provided by Non-State Govt and Private provider agencies. Private provider agencies are non-profit organizations or proprietary agencies. Non-profit organizations include not-for profit corporations formed under the NYS Law or authorized to do business in NY. The New York State (NYS) amendment seeks to amend the 1915(c) Home and Community Based Medicaid (MA) waiver, the Children's waiver, to extend it effective the approval date of the waiver;. The waiver will transition into managed care concurrent with the 1115 authority on October 1, 2019. The fiscal report will be submitted to CMS within 16 months after the close of the reporting period.

I. Definitions Applicable to this Section
a.Consolidated Fiscal Report: The Fiscal Report is the report and associated instructions utilized by all government and non-government providers to communicate annual costs incurred as a result of operating the Children's waiver programs and services,along with related patient utilization and staffing statistics.
b.Rate: A reimbursement amount based on a computation using annual provider reimbursable cost divided by the applicable annual units of service.
c. The waiver services and units of Service: The unit of measure varies by the type of service, i.e., 15 min., 30 min. or one-time occurrence.
The unit of measure used for the following waiver services are:
•Caregiver Family Supports and Services - per hour (individual, group of 2, group of 3)
•Pre-Vocational Services - per hour (individual, group of 2, group of 3)
•Community Advocacy Training and Support – per hour (individual, group of 2, group of 3)
*•Supported Employment – per hour**
•Palliative Care Pain and Symptom Management – per hour
•Palliative Care Bereavement – per hour
•Palliative Care Massage Therapy– per hour
•Palliative Care Expressive Therapy – per hour
•Respite- Planned – per hour and per diem (individual and group)
*•Respite- Crisis – less than four hours, four to 12 hours, more than 12 hours and less than 24 hours**
•Habilitation – per hour (individual, group of 2 or group of 3)
•Crisis Intervention (per 15 min and per diem)end dated 1/1/2020
•Family Support – (per 15 min)-end dated 8/1/2019
•Youth Peer Support and Training (per 15 min)- end dated 1/1/2020
II. Reporting Requirements
a.The State Government Providers, Non-State Government Providers and Private Providers shall identify provider costs in accordance with Generally Accepted Accounting Principles (GAAP.)
b.The Fiscal Reporting schedules to be completed annually are:
CCR-i - Agency Identification and Certification Statement CCR-ii/CFR-iia - Independent Accountant's Report CCR-1 - Program/Site Data
CCR-2 - Agency Fiscal Summary CCR-3 - Agency Administration
CCR-4 - CFR 4 A – Contracted Direct Care and Clinical Personal Services Personal Services

III. Services Paid via Fee Schedule: Statewide Rates for All providers
Fiscal reporting for non-profit waiver services will be subject to review. The Fiscal report will be submitted to CMS within 16 months after the close of the reporting period.
The use of retrospective reimbursement for state (public) providers, using service provider cost requires a reconciliation of any and all interim payments to the final allowable Medicaid cost for each rate year. FFP would be limited to the actual cost of the service(s) at the service provider level, or if reimbursement payments to the service provider were less and/or ultimately less than actual cost, FFP would be limited to the lower of these to actual cost or actual payments. If such total payments for any Waiver Service, subject to the annual reconciliation, exceed the final allowable Medicaid reimbursement for such rate period, the State will treat any overage as an overpayment of the federal share, and any overpayment shall be returned to CMS on the next calendar quarter CMS-64 expenditure report. If the total payments for a Waiver Service, subject to annual reconciliation, are less than the allowable Medicaid reimbursement for such rate period, the State shall be entitled to submit a claim for the federal share of such difference.

IV. Services paid using a Contract Amount
a. Environmental Modifications, Vehicle Modifications or Adaptive and Assistive Equipment
i.The Governmental Entity/MCO is the provider of record for Environmental Modifications, Vehicle Modifications or Adaptive and Assistive Equipment for billing purposes. The work is done by a contractor who is selected by the Governmental Entity using a standard bidding process, following the state rules (for FFS)or the MCO process (for managed care). Accessibility Modifications are only billed to Medicaid or the MCO once the contract work is verified as complete and the amount billed is equal to the contract value. Environmental modifications are limited to individual or family owned or controlled homes.

ii.The maximum expenditure for Environmental Modifications or Vehicle Modifications for the benefit of the individual Medicaid beneficiary may not exceed $15,000 per year. If the person requires an expenditure which exceeds the maximum expenditure amount, exceptions with medical necessity documentation may be granted by the LDSS may in conjunction with the Medicaid agency or the MCO.

V. Trend Factors
a.The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.bls.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U);
U.S. city average, by expenditure category and commodity and service group. The consolidated children's waiver rates may be trended from time to time, at the discretion of DOH and only with the approval of CMS. When trended, the trend used will be based on the CPI-U Medical Services for all Urban Consumers, as published by the BLS, over the period of the trend and extrapolated as needed.If parents/guardians of participants have any questions about the payment rates made to the Children's waiver providers, they may contact their care manager or the DOH Public Affairs Office to obtain this information.
NYSDOH is responsible for HCBS rate determination in years 3 and 4 of the waiver. NYDSOH is responsible for capitation rate determination for MCO rates that include HCBS in year 5 of the waiver.

CAH I/II Ratesetting:
Provider Reimbursement of Waiver Services
CAH I & II HCBS services are provided by Non-State Govt and Private provider agencies. Private provider agencies are non-profit organizations or proprietary agencies. Non-profit organizations include not-for profit corporations formed under the NYS Law or authorized to do business in NY. The New York State (NYS) renewal application seeks to renew the 1915(c) Home and Community Based Medicaid (MA) waiver, Care at Home I/II (CAH I/II); the waiver will then transition into Managed Care under a 1915c/1115 concurrent authority effective April 1, 2019.
The Waiver services include: Case Management, Family Palliative Care Education (Training), Bereavement Services, Massage Therapy, Expressive Therapies, Home and Vehicle Modifications.
I. Definitions Applicable to this Section
a.Consolidated Cost Report: The CFR is the report and associated instructions utilized by all government and non-government providers to communicate annual costs incurred as a result of operating CAH I, and CAH II programs and services ,along with related patient utilization and staffing statistics.
b. Rate: A reimbursement amount based on a computation using annual provider reimbursable cost divided by the applicable annual units of service.
c. Units of Service: The unit of measure varies by the type of service, i.e., 15 min., 30 min. or one-time occurrence.

The unit of measure used for the following waiver services are:
- *Case Management: 15 minutes*
- *Family Palliative Care Education(Training): 30 minutes*
- *Bereavement Services: 30 minutes*
- *Massage Therapy: 30 Minutes*
- *Expressive Therapy: 30 minutes*
- *Home and Vehicle Modifications: one time occurrence*

II. Reporting Requirements

a. The State Government Providers, Non-State Government Providers and Private Providers shall identify provider costs in accordance with Generally Accepted Accounting Principles (GAAP.)
b. The Cost Reporting schedules to be completed annually are:

CCR-i - Agency Identification and Certification Statement
CCR-ii/CFR-iia - Independent Accountant's Report
CCR-1 - Program/Site Data
CCR-2 - Agency Fiscal Summary
CCR-3 - Agency Administration
CCR-4 - CFR 4 A – Contracted Direct Care and Clinical Personal Services Personal Services

III.Services Paid via Fee Schedule: Statewide Rates for All providers

1. Case Management $22.73 15 min
2. Family Palliative Care Education (Training) $40.00 30 min
3. Bereavement Services $40.00 30 min
4. Massage Therapy $40.00 30 min
5. Expressive Therapies $40.00 30 min
6. Home & Vehicle Modifications Home Vehicle
(one-time maximum, every 5 years) $25,000 $25,000

Cost reporting for non-profit waiver services will be subject to review. The use of retrospective reimbursement, using service provider cost requires a reconciliation of any and all interim payments to the final allowable Medicaid cost for each rate year. FFP would be limited to the actual cost of the service(s) at the service provider level, or if reimbursement payments to the service provider were less and/or ultimately less than actual cost, FFP would be limited to the lower of these to actual cost or actual payments. If such total payments for any Waiver Service, subject to the annual reconciliation, exceed the final allowable Medicaid reimbursement for such rate period, the State will treat any overage as an overpayment of the federal share, and any overpayment shall be returned to CMS on the next calendar quarter CMS-64 expenditure report. If the total payments for a Waiver Service, subject to annual reconciliation, are less than the allowable Medicaid reimbursement for such rate period, the State shall be entitled to submit a claim for the federal share of such difference.

IV. Services paid using a Contract Amount
a. Home & Vehicle Modifications
i.The LDSS is the provider of record for Home & Vehicle Modifications for billing purposes. The work is done by a contractor who is selected by a standard bidding process, following the rules of the OSC. Home & Vehicle Modifications is only billed to Medicaid once the contract work is verified as complete and the amount billed is equal to the contract value. Home modifications are limited to individual or family owned or controlled homes. The maximum expenditure for Home & Vehicle Modifications for the benefit of the individual Medicaid beneficiary may not exceed $25,000 for home and $25,000 for vehicle modifications per five year period. If the person requires an expenditure which exceeds the maximum expenditure amount, the Single State Medicaid Agency may submit and seek approval of an amendment to the waiver; the Single State Agency shall provide supporting documentation as deemed necessary by CMS to support approval of the amendment. For the remainder, see I-5-b

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For FFS, billings flow directly from the provider to New York State's MMIS (eMedNY).
1)The following services are reimbursed through a fee rate schedule that has upstate and downstate rates:
• Community Habilitation.
• Day Habilitation
• Caregiver/Family Supports and Services.
• Respite.
• Prevocational Services.
• Supported Employment.
• Community Self-Advocacy Training and Support.
• Non-Medical Transportation.
• Adaptive and Assistive Equipment.
• Palliative Care Expressive Therapy
• Palliative Care Massage Therapy
• Palliative Care Bereavement Services
• Palliative Care Pain and Symptom Management
• Crisis intervention-end dated 1/1/2020
• Family Support-end dated 8/1/2019
• Youth Peer training and support- end dated 1/1/2020
FFS Environmental Modifications, Vehicle Modifications and Adaptive and Assistive Equipment purchases do not result in a claim to eMedNY because such projects are contracted. Instead, NYS utilizes a vendor bid process for home and vehicle modifications; and payments are made to the provider by the governmental entity. See Appendix I-3 g-I for voluntary reassignment of payments for additional information.
For all HCBS through the MCO for years 3 and 4 of the waiver, billings flow directly from the provider to the MCO. Capitation payments for HCBS will not begin until at least waiver year five. The MCO receives a capitated payment from the NYSDOH MMIS eMedNY. Billings flow directly from the provider to the MCO. The MCO receives a non-risk payment after invoicing the NYSDOH MMIS eMedNY in years 3 and 4 of the waiver for the services paid. The MCO receives a capitated payment from the NYSDOH MMIS eMedNY. The MCO billings to the state are made in accordance with the provisions of the 1115 waiver and provider billings to the MCO are made in the terms of the provider's contract with the MCO.
The MCOs will secure a local vendor qualified to complete the required work for Environmental Modifications, Vehicle Modifications and/or Adaptive and Assistive Equipment Vendors using its own procurement/contracting processes. Services are only billed to the MCO once the equipment is verified as received and the amount billed is equal to the contract value. Billings flow directly from the provider to the MCO. The MCO receives a non-risk payment after invoicing the NYSDOH MMIS eMedNY in years 3 and 4 of the waiver for the services paid. The MCO receives a capitated payment from the NYSDOH MMIS eMedNY.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

For both FFS and managed care, the State will ensure that a percent of claims is verified through the eMedNY compliance audit to have paid in accordance with the participant's waiver POC using a sampling methodology with a 95% confidence interval and reported on a quarterly basis.

Fee-for-service
Claims for all HCBS waiver services are adjudicated by eMedNY. The eMedNY system identifies HCBS enrollees with codes (Restriction/Exemption/RE) that identify the person as HCBS enrolled and the effective date of the enrollment.

Payment system edits require the client record to indicate active Medicaid eligibility and HCBS Waiver enrollment for all dates of service billed. All FFS billings are processed either through eMedNY or through direct payment to the vendor by the governmental entity for Environmental Modifications, Vehicle Modifications , or adaptive or assistive equipment and will be subjected to eligibility and payment edits. All managed care billings are processed through the MCO which is subject to the External Quality Review process.

For waiver services adjudicated through eMedNY, Children's participants' eligibility for the waiver services on the date of the claim is verified through the payment system edits. Environmental Modifications, Vehicle Modifications and Adaptive or Assistive Equipment services, the responsible governmental entity verifies: participants' eligibility for the service services on the date of the claim, date of service delivery, plan of care identification as authorized service for the Accessibility Modification project as medically necessary.

Prior to the final payment for Environmental Modifications or Vehicle Modifications, the governmental entity staff, contractor or/and case manager verifies the completion by assuming a signed statement of satisfactory completion by the parent/legal guardian of the beneficiary. A copy of the statement is maintained as part of the case.

If an overpayment is discovered, the provider is requested to repay the state via check or withholding of payments. OMIG submits a weekly action report to DOH requesting specific transactions be made in relation to each active OMIG Account Receivable (A/R). These transactions include but are not limited to, establishing an A/R, withholding provider payments from prospective MA billings, refunding underpayments, and suspending MA payments. OMIG Collections compiles information from DOH and OMIG activities to receive and reconcile receipts against OMIG A/Rs. Currently, this process is limited to FFS transactions.

Managed Care
When an individual has been determined to be eligible for the waiver, the HHCM/IEIE sends notification to NYSDOH or its designee through the HCS system.

A plan of care (POC) is developed for all participants served through the waiver. All waiver services on the plan of care are authorized by the MCO. Communication between the HH/IE and the MCO will occur to ensure that the plan of care is received, reviewed, and approvals are processed in a timely manner as detailed below.

When a waiver service claim is submitted to the MCO, the MCO's system electronically checks the plan of care and the eligibility roster to ensure the child/youth is waiver eligible for the dates of services included on the claim. In addition, the MCO's system electronically checks the provider file to assure the provider is enrolled with the MCO and is approved to receive Medicaid waiver payment for the date of services.

The MCO conducts post pay reviews to validate waiver services were in fact provided as billed. This financial integrity review is included in the MCO's fraud and abuse prevention and detection plan in compliance with managed care regulations at 42 CFR 438 Subpart H including requirements at 438.608(a)(1)(vii) and (5). This includes determining the accuracy of documentation, eligibility, services provided, and units billed. The MCOs a sample members and report on a quarterly basis to verify actual service delivery against the EOB (claims processed).

See I-3-a for remainder

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Appendix I-2-d continued below:
Providers must ensure that the services are provided in accordance with the approved plan of care, maintain adequate supporting documentation of services provided and submit claims that captures services provided.
MCO post payment reviews frequency, confidence level, content, and clarify if the reviews include any on-site reviews. If on-site reviews are conducted, please explain the process for sampling and the percent of claims with on-site reviews MCOs may employ a variety of mechanisms to conduct post-payment reviews, as reported to the State at least annually in the MCO's fraud and abuse detection prevention plan, including some or all of the following, depending on each MCO's specific program integrity design and size of the enrolled population: quarterly direct mailing to a statistically valid sample (95% confidence or greater) of enrollees who incurred medical claims to confirm if the service billed was provided; issuance of EOBs and encouraging enrollees to review billed services, and corresponding trained member services staff to respond to enrollee's inquiries regarding suspect EOBs; "secret shopper" programs; ongoing data mining utilizing advance software to conduct predictive analytics and statistical modeling to identify and assess patterns indicating fraudulent billing; "red flagging" providers with identified suspect activity for enhanced review and investigation; internal audits and internal controls to confirm claims are adjudicated based on provider fee schedules and appropriate coding; investigation of internal and external referrals indicating potential fraud or abuse; and quarterly and annual trend reports indicating activity that requires escalated review by senior officers of the MCO. When necessary based on identified issues from claims reviews, MCOs may review a significantly valid sample of medical chart records from providers for confirmation of services billed. More rarely, MCOs may also conduct on-site provider reviews, which may be conducted by contracted expert investigative companies.

Overview of the state's post payment review process of MCOs including the frequency, confidence level, content, and clarify if the reviews include any on-site reviews. If on-site reviews are conducted, please explain the process for sampling and the percent of claims with on-site reviews. The state has begun conducting audits of MCO network providers and the volume of audits conducted is dependent on available resources and priorities. The purpose of these audits is to validate the Medicaid payments and determine if appropriate documentation is maintained to support the claims. The audits generally include a sample of 100 claims drawn from the claim universe, which are then extrapolated using a 90% confidence level. Depending on the claim payment variance, the sample in some instances may be stratified. The record reviews are completed entirely on-site.

Audits are conducted on a rolling basis and there is not a regular schedule for conducting these audits. They are conducted on a rolling basis, and as needed. The state utilizes data analysis, or reviews allegations that are received, and develops targets for audit.

The time period covered in the selected sample is a 1 or 2 year audit period.

The percentage of total claims paid represented in the 100 claims varies by each universe. Per our department statistician, 100 claims is the minimum sample size for our purposes.

OMIG utilizes a 90% TWO-SIDED confidence interval, which is equivalent to a 95% ONE-SIDED confidence interval. This is the same as is used by the Federal OIG in their reviews.

The state's process for recoupment of payments for inappropriate billings: If an overpayment is discovered, the provider is requested to repay the state via check or withholding of payments. OMIG submits a weekly action report to DOH requesting specific transactions be made in relation to each active OMIG Account Receivable (A/R). These transactions include but are not limited to, establishing an A/R, withholding provider payments from prospective MA billings, refunding underpayments, and suspending MA payments. OMIG Collections compiles information from DOH and OMIG activities to receive and reconcile receipts against OMIG A/Rs. Currently, this process is limited to FFS transactions. However, DOH currently transacts recoupments against MCOs, and therefore OMIG can mirror existing processes to recoup MA funds from MCOs where appropriate.

Appendix I-3-a starts below

Payments for HCBS in FFS are all made through the eMedNY except for Assistive Technology, Environmental and Vehicle Modifications. For Environmental modifications, Vehicle modifications, and/or adaptive and accessibility equipment paid for FFS children, the Governmental Entity verifies the child's eligibility and makes a partial payment to the contractor at outset of the project. The Governmental Entity makes the final contract payment when

it determines that the project has been completed as identified in the recipient's plan of care and receives the parent's signoff that the work has been completed satisfactorily. Governmental Entity reports these expenditures in accordance with the NYS Fiscal Reference Manual. The Governmental Entity also authorizes these expenditures in the Welfare Management System (WMS) with a pay type of P9 and special claiming categories of V for federally participating, R for federally non- participating, and N for Non- Reimbursable. These expenditures are then entered in the State's Automated Claims System which is used to generate the quarterly CMS-64 report. Data to support the claim is maintained at the Governmental Entity for annual DOH review and audit purposes. In addition, Environmental and Vehicle Modifications are reviewed as part of the NYSDOH annual sample review of cases. No earlier than waiver year 5 the MCO entity is paid a monthly capitation rate through the MMIS.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I-3-a continued below:
Payments for HCBS to managed care enrollees will be through the MCO beginning 4/1/2019. In waiver years 3 and 4, HCBS will be paid non-risk through the MCO per 42 CFR 447.361 subject to the non-risk UPL. After two years, the managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS (eMedNY).
The payment method for Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Equipment billed through MCOs and include this clarification in I-3-a. (218): The MCOs will secure a local vendor qualified to complete the required work for Environmental Modifications, Vehicle Modifications and/or Adaptive and Assistive Equipment Vendors using its own procurement/contracting processes. Activities include and are not limited to determining the need for the service, the safety of the proposed equipment, its expected benefit to the child, and the most cost effective approach to fulfill the child's need. Services are only billed to Medicaid or the MCO once the equipment is verified as received and the amount billed is equal to the contract value.

Appendix I-3-d starts below:
Assistive Technology, Vehicle Modifications and Environmental Modifications - A governmental provider may be the provider of record for Vehicle Modifications or Environmental Modifications. The term provider of records indicates that a governmental entity may contract with another private entity for the provision of services. There are no State or local government providers approved to provide Assistive Technology, Vehicle Modifications or Environmental Modifications.

County mental health and substance use disorder agencies may choose to participate in the waiver. These entities can provide any waiver service, providing they meet the qualifications established in Appendix C of this application.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for*

expenditures made by states for services under the approved waiver. Select one:

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

There are no reductions or returns to the state that result in a disparity between the amount claimed to CMS and the amounts actually paid to the MCO. However, please note, that not all providers will be paid by an MCO. Only providers providing services to children in the managed care delivery system in year five will be paid by an MCO. There will be a portion of children under the Children's Waiver (approximately 51% of enrollees) who remain in FFS.

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

In FFS, Environmental modifications, Vehicle Modifications and Adaptive and Assistive Equipment are the only HCBS for which payments are reassigned. Vendors are required to sign a Statement of Reassignment that they will only bill the Governmental Entity for the adaptation specified in the child's approved plan and accept the contracted amount as payment in full. Furthermore, the vendor acknowledges that the Governmental Entity will request MA reimbursement via Schedule E, on behalf of the vendor, and retain any reimbursement obtained for these services. This process is specified in state guidance.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ◉ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☒ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

For FFS services delivered by provider agencies and managed care payments, the source of funds for the State share is tax revenues appropriated to NYSDOH. When provider agencies bill eMedNY for payment, the Department of Health funds the non- federal share expenditures.

State tax revenues are the source of funds for the state share for HCBS Waiver services delivered by NYSDOH. State funded appropriations support the State Share of Children's waiver claims. The federal share of Children's waiver funds is drawn down based on State Share claims. Such claims are adjudicated through e-MedNY.

The Medicaid State share is also provided through appropriations in NYSDOH for funds (net of any federal share) received from drug rebates, audit recoveries and refunds, third party recoveries; assessments on nursing home and hospital gross revenue receipts; and Health Care Reform Act (HCRA) revenues.

The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office of Mental Health (OMH), NYS Office for People With Developmental Disabilities (OPWDD), OCFS, NYS Office of Alcoholism and Substance Abuse Services, and NYS State Education Department budgets. Appropriations in OPWDD for the Mental Hygiene Patient Income Account and in OMH for HCRA also fund the State share of Medicaid and are transferred to NYSDOH. Funds are transferred from these agencies, upon approval from the NYS Division of Budget, to the NYS Department of Health (NYSDOH) using the certificate of approval process (funding control mechanism specified in the State Finance Law, or through journal transfers to NYSDOH).

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Counties in New York State and the City of New York have the authority to levy taxes and other revenues. These local entities may raise revenue in a variety of ways, including taxes, surcharges and user fees. The State, through a state/county agreement, has an established system by which local entities are notified at regular intervals of the local share of Medicaid expenditures for those individuals for which they are fiscally responsible. In turn, the local entities remit payment of these expenditures directly to the State.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Room and Board costs, as defined by federal regulation, are included in only two (2) Children's waiver services, and then only for subsets of those services. They are: Planned and Crisis Respite Services that are provided in a qualifying residence or facility. Those two sub-sets have rate methodologies that include room and board costs, in accordance with 42 CFR 441.310(a) (2). Duplication of payments is prohibited.

Appendix I-2-a Continued
Family Peer Support Services is no longer covered in the waiver beginning 8/1/2019.
V.Trend Factors
a. The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.bls.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.
These cost reports will be used to reconcile the Medicaid payments for waivers. If parents/guardians of CAH I/II participants have any questions about the payment rates made to the agencies CAH I&II providers, they may contact the LDSS, their case manager or the DOH Public Affairs Office to obtain this information.

Children's Waiver ratesetting:
The current 1915(c) waiver amendment is a consolidation of six historical 1915(c) waivers for Behavioral Health (BH) Children. Rates were developed using historical 1915(c) waiver rates that are currently in effect. Adjustments were applied to account for differences in the historical 1915(c) waiver requirements relative to the current 1915(c) consolidated waiver application. There are significant differences in rates for similar services across historical 1915(c) waivers. Based on this and the recognition of the fact that there is a critical need to insure access to services, an adjustment was applied to get to generally sufficient rate levels. Additional adjustments for differences in staff qualification requirements, legislative wage increases, unit cost trends, regional cost differentiation, and plan administrative expenses were also accounted for.

Several services can be provided in either an individual or in group setting. Additionally, some services are available for extended periods of time, which will utilize per diem rates. All rates described below are assumed to be for an individual setting and an hour of service unless otherwise indicated. In general, group rates are developed based on applying an adjustment to the individual rates, while per diems were developed separately from associated individual rates and may vary for different lengths of time.

The following services used the OPWDD 1915(c) "Comprehensive" waiver or Bridges to Health 1915(c) waiver as the basis for the rate developed for the consolidated 1915(c) waiver:
•Caregiver Family Supports and Services – Individual:
•Prevocational Services – Individual:
•Community Advocacy and Support - Individual:
•Palliative Care:
•Planned Respite - Individual:
•Day Habilitation – Individual:
•Crisis Respite:

Adjustments applied to account for differences in the base rate and services to be delivered include:
- Provider Neutrality - Factor applied to account for rate differences across 1915(c) waivers being consolidated and considerations for maintaining sufficient levels of access to services
- Legislated Wage Initiatives – Wage adjustments for legislatively mandated increases:
- Minimum wage changes effective 12/31/17 and 12/31/2018
- Direct and clinical care worker specific wage increases effective 1/1/2018 and 4/1/2018
- Unit Cost Trend - Unit cost inflation factor based on 5-year average of July to July Annual CPI-U Medical Services
- Regional Adjustment Factor - Adjusts for service cost differences, primarily related to staff wage differentials, between upstate and downstate regions
- Plan Administrative Expenses Load - Administrative expense adjustment applied for plans to administer the services on a non-risk basis prior to being carved into the capitation rates on an at-risk basis
- Group Size Adjustment (Group Rates Only) – Applies productivity adjustment to the individual service rate to determine group rates for group sizes of 2 and 3

Similarly, the following services used the OPWDD 1915(c) "Comprehensive" waiver as the basis for the rate developed for the consolidated 1915(c) waiver:

• Supported Employment:
• Planned Respite – Per Diem:
• Crisis Respite – Per Diem:
Adjustments applied to account for differences in the base rate and services to be delivered include:
- Legislated Wage Initiatives – Wage adjustments for legislatively mandated increases:
- Minimum wage changes effective 12/31/17 and 12/31/2018
- Direct and clinical care worker specific wage increases effective 1/1/2018 and 4/1/2018
- Unit Cost Trend - Unit cost inflation factor based on 5-year average of July to July Annual CPI-U Medical Services
- Regional Adjustment Factor - Adjusts for service cost differences, primarily related to staff wage differentials, between upstate and downstate regions
- Plan Administrative Expenses Load - Administrative expense adjustment applied for plans to administer the services on a non-risk basis prior to being carved into the capitation rates on an at-risk basis

The OPWDD 1915(c) "Comprehensive" waiver Community Habilitation rate is the basis for the Community Habilitation rate for the consolidated 1915(c) waiver. The OPWDD 1915(c) "Comprehensive" waiver Community Habilitation rate is the basis for the Community Habilitation rate for the consolidated 1915(c) waiver. OPWDD changed the reimbursement methodology for At-Home Residential Habilitation from a per diem rate to a regional hourly fee (billed in 15-minute increments), effective February 1, 2009. The service became Hourly Community Habilitation on November 1, 2010.
-The components of the reimbursement methodology were based on cost data from 2005-06 (Fiscal) and 2006 (Calendar) years.
**Direct care salary component set to the 85th percentile of regional cost. The related fringe benefit percentage was set at the 75th percentile of statewide cost.*
**Clinical oversight component was included to allow for clinical support to Habilitation staff in the field*
**Non-Personal Service component was included to cover costs such as staff and participant travel, supplies, participant expenses, staff training. Also includes an adjustment for non-face-to-face time spent on paperwork and follow-up*
**Administration component was included to cover general and administrative overhead costs*
**Group Size Adjustment (Group Rates Only) – Applies productivity adjustment to the individual service rate to determine group rates for group sizes of 2 and 3*
A weighted average was applied to consolidate from OPWDD's 3 regions to align with the 2 region designation under the Children's waiver
The rate development methodology for Youth Peer Support and Training, Family Peer Support Services and Crisis Intervention primarily were composed of provider cost modeling, through New York provider compensation studies and cost data.(Note: Family Peer Support is no longer covered in the waiver beginning 8/1/2019.Youth Peer Support and Training and Crisis Intervention are no longer covered in the waiver beginning 1/1/2020) Rates from similar State Medicaid programs were considered as well. The following list outlines the major components of the cost model used in the rate development:
- Staffing ratios and productivity assumptions
- Staff wage assumptions - Based on NY specific BLS data
- Employee-related expenses – benefits, employer taxes, (e.g. Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)
- Program-related expenses (e.g. supplies)
- Provider overhead expenses
Adjustments applied to account for differences in the base rate and services to be delivered include:
- Legislated Wage Initiatives – Wage adjustments for legislatively mandated increases:
- Direct and clinical care worker specific wage increases effective 1/1/2018 and 4/1/2018
- Regional Adjustment Factor - Adjusts for service cost differences, primarily related to staff wage differentials, between upstate and downstate regions
- Group Size Adjustment (Group Rates Only) – Applies productivity adjustment to the individual service rate to determine group rates for group sizes of 2 or more

New York will ensure rate sufficiency consistent with the November 2016 guidance and January 2019 technical guide to ensure access to services including:
1. Date the rates were initially set and last reviewed:
CAH I/II - New York reviewed and set the rates for the Children's waiver effective April 1, 2017
Children's Waiver - Because this is a major program change, New York reviewed and set the rates for the Children's waiver effective April 1, 2019.

2. NY measures rate sufficiency and compliance with §1902(a)(30)(A) of the Act;
DOH will utilize techniques outlined in the CMS training Ensuring Rate Sufficiency: Rate Review and Revision Approaches – November 2016 to ensure access

3. The rate review method(s) used;
DOH will utilize the following three methods.
-Analyze and incorporate feedback from stakeholders specifically
O Collect data on Fair Hearings, grievances or complaints related to lack of providers
O Complement Fair Hearing and grievance/complaint information with data from individual and provider surveys
-Collect evidence from QIS D, Sub-assurance whether services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. If individuals are not receiving services in accordance with the service plan, it could indicate that there are insufficient providers to meet individuals' needs.
-Measure changes in provider capacity. Measure the change in the number of new providers and those providers' capacity following a change in waiver service rates. Request provider capacity information (e.g., staff turnover, retention, etc) approximately a year after the rate change. Compare provider capacity information to the percentage change in enrollment for the previous two years or more.
4. The frequency of rate review activities.
DOH will review the feedback from stakeholders, evidence from QIS D, and changes in provider capacity at least annually.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	9730.20	203764.00	213494.20	139580.00	136044.00	275624.00	62129.80
2	9629.00	212471.00	222100.00	145559.00	141749.00	287308.00	65208.00
3	4850.33	40052.00	44902.33	203678.00	27786.00	231464.00	186561.67
4	4029.78	40608.00	44637.78	209384.00	28564.00	237948.00	193310.22
5	4187.32	40871.00	45058.32	215248.00	29364.00	244612.00	199553.68

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	1600	256	1343	1
Year 2	1755	281	1473	1
Year 3	11649	8688	1900	1061
Year 4	14515	10826	2367	1322
Year 5	17379	12962	2835	1582

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The value for years 1 and 2 is 309 days and is from the most recent CAH I/II application. The average length of stay is calculated by applying the trend factor for enrollment growth of all new unduplicated recipients based on prior 372 reports. That amount is added to the unduplicated count of recipients at the previous each waiver year.
That total is divided by the total unduplicated recipient count, and then multiplied by the annual days in the waiver year.

For years 3-5, the 287 days is a weighted average for the consolidated waivers. The State has calculated the weighted average of all unduplicated recipients based on prior 372 reports, approved waiver applications and actual HCBS claims paid data for children. The value used in this application is the weighted average (based on recip counts) for the consolidating waivers. To calculated the weighted average the most recent waiver applications for Care at Home 1 and 2, Bridges to Health (SED, DD, and Med Frag), and OMH SED were used. For CAH 3,4,6 (now combined into CAH 4), the value used is from the most recent 372.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

For years 1 and 2, Factor D values are estimated based on established payment rates of each waiver service, the number of units of service expected to be delivered annually, multiplied the number of participants expected to receive to each service.

The basis for these estimates is as follows: For year 1 of the waiver, D is calculated using the values for year 1 of the CMS-approved Care At Home I/II waiver application, that being the period beginning 4/1/17. For year 2, D was calculated in the same manner (using the data for year 2 of the approved waiver For year 3, D was calculated based on the actual 2017 spend for the six consolidating waivers (CAH 1/II, CAH III/IV/VI, B2H SED, B2H DD, B2H Med Frag, OMH SED), trended by the CPI for All Urban Consumers to 4/1/19 and less the services moving under 1115/SPA authority; which are health home, CPST, PSR, and YPA. To the remaining waiver services was added $13.5 million in savings resulting from moving to health home care management. That value was reinvested to cover the cost of additional waiver enrollments/slots. Beginning in July 2019, waiver recipients ramp up by 190 persons per month, which results in the unduplicated recipients figure of 11,649. For year 4, D was calculated in a similar manner, trended to 4/1/20, and with a health home savings reinvestment of $36.5 million, bringing the total unduplicated recipients to 14,515 by 3/31/21. For year 5, again the same methodology was used, with a health home savings reinvestment of $48 million, and total unduplicated recipients of 17,379 (total slots are 13,894). The health home savings results from lower care management costs under health home. A time limited legacy payment for TCM transitioning to health homes causes those savings to rise from $13.5 million in year 3 to $48 million in year 5.

The estimates in J-2-d for Environmental and Vehicle Modifications was changed from $25,000 per 5 years in the previously approved waiver to $15,000 per year in the amendment application. The maximum expenditure of $15,000 per year in Years 3-5 reflects the average expected cost for all 6 waiver populations combined, which is a lower weighted average than the $25,000 CAH I/II average cost per unit in the initial years of the waiver prior to adding the other populations.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

For years 1 and 2: Factor D' values are based on years 1 and 2 from the previously approved waiver application for CAH I/II. For year 3, D' is the actual non-waiver spend for the combined waivers for CY 2017 trended to 4/1/19. To that was added the value of health home care management and the health home hold harmless amount for year 3 ($34.4 million), the value of the waiver services moving to 1115/SPA authority (CPST/PSR/YSA), and an estimated impact for the new SPA services of $30 million. For year 4, the calculation is the same except that the health home legacy payment drops to $11.5 million and the SPA services impact rises to $62.9 million. For year 5, there is no health home legacy payment under the 1115. The SPA services impact rises to $76.3 million.

The trend was developed using CPI for All Urban Consumers data through May 2018. A projected annual trend of 2.801% was developed by taking the May 2018 index (251.588) divided by the May 2017 index (244.733). Trending forward from May 2018 to April 2019 at 2.801% yielded an April 2019 index value of 258.124. That value divided by the January 2017 value of 242.839 yielded the trend factor used from Jan 2017 to April 2019, which was 6.294%. The mid-point of the periods could have been used instead, but that would have yielded essentially the same trend value and would have required the projection into 2019 to extend for another 6 months.

iii. **Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G values were estimated using NYS actual expenditure data for nursing home and hospital care of child Medicaid recipients of the same age who have comparable disabilities to CAH I/II participants for dates of service during the 2010-11 waiver year. This information is generated from the eMedNY, AFPP Data Mart Claims system. [See Appendix I-1 for description of the eMedNY system.]

The basis of these estimates is as follows: For years 1 and 2 of the waiver, G is uses the values from the approved CAH 1/II waiver application. For years 3 through 5, G uses the values for the combined waivers, weighted based on the number of existing recipients in each waiver. The values for CAH III/IV/VI and OMH SED are from the most recent 372. The values for the other waivers are from the most recent waiver applications.

iv. **Factor G' Derivation.** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' values were estimated by using NYS actual expenditure data for all non-institutional MA State Plan services for the same Medicaid recipient group as for Factor G for dates of service during the 2010-11 waiver year. This information is generated from the eMedNY AFPP Data Mart Claims system.

The basis of these estimates is as follows: For years 1 and 2 of the waiver, G' is uses the values from the approved CAH 1/II waiver application. For years 3 through 5, G' uses the values for the combined waivers. The values for CAH III/IV/VI and OMH SED are from the most recent 372. The values for the other waivers are from the most recent waiver applications.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Community Habilitation	
Day Habilitation	
Prevocational Services	
Respite	
Supported Employment	
Adaptive and Assistive Equipment	

Waiver Services	
Caregiver/Family Supports and Services	
Community Self-Advocacy Training and Supports	
Crisis Intervention	
Environmental Modifications	
Family Peer Support Services	
Non-Medical Transportation	
Palliative care - Expressive Therapy	
Palliative care – Bereavement Service	
Palliative care – Massage Therapy	
Palliative care – Pain and Symptom Management	
Vehicle Modifications	
Youth Peer Support and Training	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							8728320.00
Case Management	☐	Hour	1600	60.00	90.92	8728320.00	
Community Habilitation Total:							0.00
Community Habilitation	☐	Hour	1	0.01	0.01	0.00	
Community Habitation Capitated	☐	Hour	0	0.01	0.01	0.00	
Day Habilitation Total:							240000.00
Day Habilitation	☐	Hour	100	60.00	40.00	240000.00	
Day Habilitation Capitated	☐	Hour	0	0.01	0.01	0.00	
Prevocational Services Total:							240000.00

GRAND TOTAL:	15568320.00
Total: Services included in capitation:	
Total: Services not included in capitation:	15568320.00
Total Estimated Unduplicated Participants:	1600
Factor D (Divide total by number of participants):	9730.20
Services included in capitation:	
Services not included in capitation:	9730.20
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services	☐	Hour	100	60.00	40.00	240000.00	
Prevocational Services Capitated	☐	Hour	0	0.01	0.01	0.00	
Respite Total:							0.00
Respite	☐	Hour	1	0.01	0.01	0.00	
Respite Capitated	☐	Hour	0	0.01	0.01	0.00	
Supported Employment Total:							0.00
Supported Employment	☐	Hour	1	0.01	0.01	0.00	
Supported Employment Capitated	☐	Hour	0	0.01	0.01	0.00	
Adaptive and Assistive Equipment Total:							0.00
Adaptive and Assistive Equipment	☐	15 mins	0	0.01	0.01	0.00	
Adaptive and Assistive Equipment Capitated	☐	15 mins	0	0.01	0.01	0.00	
Caregiver/Family Supports and Services Total:							400000.00
Caregiver/Family Support and Services	☐	Hour	100	100.00	40.00	400000.00	
Caregiver/Family Support and Services Capitated	☐	Hour	0	0.01	0.01	0.00	
Community Self-Advocacy Training and Supports Total:							0.00
Community Self-Advocacy Training and Supports	☐	Hour	0	0.01	0.01	0.00	
Community Self-Advocacy Training and Support Capitated	☐	Hour	0	0.01	0.01	0.00	
Crisis Intervention Total:							0.00
Crisis Intervention	☐					0.00	

GRAND TOTAL:	15568320.00
Total: Services included in capitation:	
Total: Services not included in capitation:	15568320.00
Total Estimated Unduplicated Participants:	1600
Factor D (Divide total by number of participants):	9730.20
Services included in capitation:	
Services not included in capitation:	9730.20
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 mins	0	0.01	0.01		
Crisis Intervention per diem	☐	Per diem	0	0.01	0.01	0.00	
Environmental Modifications Total:							5000000.00
Environmental Modifications	☐	Project	200	1.00	25000.00	5000000.00	
Environmental Modifications Capitated	☐	Project	0	0.01	0.01	0.00	
Family Peer Support Services Total:							0.00
Family Support	☐	15 mins	0	0.01	0.01	0.00	
Non-Medical Transportation Total:							0.00
Non-Medical Transportation	☐	Trip	1	0.01	0.01	0.00	
Palliative care - Expressive Therapy Total:							240000.00
Palliative care-Expressive Therapy	☐	Hour	100	60.00	40.00	240000.00	
Palliative care-Expressive Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care - Expressive Therapy	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Bereavement Service Total:							480000.00
Palliative care-Bereavement Service	☐	Hour	100	120.00	40.00	480000.00	
Palliative care-Bereavement Service Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Massage Therapy Total:							240000.00
Palliative care-Massage Therapy	☐	Hour	100	60.00	40.00	240000.00	
Palliative care-Massage Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Pain and Symptom							0.00

GRAND TOTAL:	15568320.00
Total: Services included in capitation:	
Total: Services not included in capitation:	15568320.00
Total Estimated Unduplicated Participants:	1600
Factor D (Divide total by number of participants):	9730.20
Services included in capitation:	
Services not included in capitation:	9730.20
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management Total:							
Palliative care-Pain and Symptom Management	☐	Hour	1	0.01	0.01	0.00	
Palliative care-Pain and Symptom Management Capitated	☐	Hour	0	0.01	0.01	0.00	
Vehicle Modifications Total:							0.00
Vehicle Modifications	☐	Project	1	0.01	0.01	0.00	
Vehicle Modifications Capitated	☐	Project	0	0.01	0.01	0.00	
Youth Peer Support and Training Total:							0.00
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	

GRAND TOTAL:	15568320.00
Total: Services included in capitation:	
Total: Services not included in capitation:	15568320.00
Total Estimated Unduplicated Participants:	1600
Factor D (Divide total by number of participants):	9730.20
Services included in capitation:	
Services not included in capitation:	9730.20
Average Length of Stay on the Waiver:	309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							9573876.00

GRAND TOTAL:	16898876.00
Total: Services included in capitation:	
Total: Services not included in capitation:	16898876.00
Total Estimated Unduplicated Participants:	1755
Factor D (Divide total by number of participants):	9629.00
Services included in capitation:	
Services not included in capitation:	9629.00
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management	☐	Hour	1755	60.00	90.92	9573876.00	
Community Habilitation Total:							0.00
Community Habilitation	☐	Hour	0	0.01	0.01	0.00	
Community Habitation Capitated	☐	Hour	0	0.01	0.01	0.00	
Day Habilitation Total:							0.00
Day Habilitation	☐	15 mins	0	0.01	0.01	0.00	
Day Habilitation Capitated	☐	15 mins	0	0.01	0.01	0.00	
Prevocational Services Total:							0.00
Prevocational Services	☐	Hour	0	0.01	0.01	0.00	
Prevocational Services Capitated	☐	Hour	0	0.01	0.01	0.00	
Respite Total:							0.00
Respite	☐	Hour	0	0.01	0.01	0.00	
Respite Capitated	☐	Hour	0	0.01	0.01	0.00	
Supported Employment Total:							0.00
Supported Employment	☐	Hour	0	1.00	0.01	0.00	
Supported Employment Capitated	☐	Hour	0	0.01	0.01	0.00	
Adaptive and Assistive Equipment Total:							0.00
Adaptive and Assistive Equipment	☐	Project	0	1.00	0.01	0.00	
Adaptive and Assistive Equipment Capitated	☐	Project	0	0.01	0.01	0.00	
Caregiver/Family Supports and Services Total:							500000.00
Caregiver/Family Support and Services	☐	Hour	125	100.00	40.00	500000.00	

GRAND TOTAL:	16898876.00
Total: Services included in capitation:	
Total: Services not included in capitation:	16898876.00
Total Estimated Unduplicated Participants:	1755
Factor D (Divide total by number of participants):	9629.00
Services included in capitation:	
Services not included in capitation:	9629.00
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiver/Family Support and Services Capitated	☐	Hour	0	0.01	0.01	0.00	
Community Self-Advocacy Training and Supports Total:							0.00
Community Self-Advocacy Training and Supports	☐	Hour	0	0.01	0.01	0.00	
Community Self-Advocacy Training and Support Capitated	☐	Hour	0	0.01	0.01	0.00	
Crisis Intervention Total:							0.00
Crisis Intervention	☐	15 mins	0	0.01	0.01	0.00	
Crisis Intervention per diem	☐	Per Diem	0	0.01	0.01	0.00	
Environmental Modifications Total:							5625000.00
Environmental Modifications	☐	Project	225	1.00	25000.00	5625000.00	
Environmental Modifications Capitated	☐	Project	0	0.01	0.01	0.00	
Family Peer Support Services Total:							0.00
Family Support	☐	15 mins	0	0.01	0.01	0.00	
Non-Medical Transportation Total:							0.00
Non-Medical Transportation	☐	Trip	0	0.01	0.01	0.00	
Palliative care - Expressive Therapy Total:							300000.00
Palliative care-Expressive Therapy	☐	Hour	125	60.00	40.00	300000.00	
Palliative care-Expressive Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care - Expressive Therapy	☐	Hour	0	0.01	0.01	0.00	
Palliative care –							600000.00

GRAND TOTAL:	16898876.00
Total: Services included in capitation:	
Total: Services not included in capitation:	16898876.00
Total Estimated Unduplicated Participants:	1755
Factor D (Divide total by number of participants):	9629.00
Services included in capitation:	
Services not included in capitation:	9629.00
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Bereavement Service Total:							
Palliative care-Bereavement Service	☐	Hour	125	120.00	40.00	600000.00	
Palliative care-Bereavement Service Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Massage Therapy Total:							300000.00
Palliative care-Massage Therapy	☐	Hour	125	60.00	40.00	300000.00	
Palliative care-Massage Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Pain and Symptom Management Total:							0.00
Palliative care-Pain and Symptom Management	☐	Hour	0	0.01	0.01	0.00	
Palliative care-Pain and Symptom Management Capitated	☐	Hour	0	0.01	0.01	0.00	
Vehicle Modifications Total:							0.00
Vehicle Modifications	☐	Project	0	0.01	0.01	0.00	
Vehicle Modifications Capitated	☐	Project	0	0.01	0.01	0.00	
Youth Peer Support and Training Total:							0.00
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	

GRAND TOTAL:	16898876.00
Total: Services included in capitation:	
Total: Services not included in capitation:	16898876.00
Total Estimated Unduplicated Participants:	1755
Factor D (Divide total by number of participants):	9629.00
Services included in capitation:	
Services not included in capitation:	9629.00
Average Length of Stay on the Waiver:	309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that*

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							0.00
Case Management	☐	Hour	0	0.01	0.01	0.00	
Community Habilitation Total:							552000.00
Community Habilitation	☐	Hour	460	16.00	75.00	552000.00	
Community Habitation Capitated	☐	Hour	0	0.01	0.01	0.00	
Day Habilitation Total:							3123750.00
Day Habilitation	☐	15 mins	1190	35.00	75.00	3123750.00	
Day Habilitation Capitated	☐	15 mins	0	0.01	0.01	0.00	
Prevocational Services Total:							562800.00
Prevocational Services	☐	Hour	268	35.00	60.00	562800.00	
Prevocational Services Capitated	☐	Hour	0	0.01	0.01	0.00	
Respite Total:							26988000.00
Respite	☐	Hour	4498	100.00	60.00	26988000.00	
Respite Capitated	☐	Hour	0	0.01	0.01	0.00	
Supported Employment Total:							90000.00
Supported Employment	☐	Hour	20	50.00	90.00	90000.00	
Supported Employment Capitated	☐	Hour	0	0.01	0.01	0.00	
Adaptive and Assistive Equipment Total:							881500.00
Adaptive and Assistive Equipment	☐	Project	215	1.00	4100.00	881500.00	
Adaptive and Assistive	☐	Project	0	0.01	0.01	0.00	

GRAND TOTAL:	56501527.04
Total: Services included in capitation:	
Total: Services not included in capitation:	56501527.04
Total Estimated Unduplicated Participants:	11649
Factor D (Divide total by number of participants):	4850.33
Services included in capitation:	
Services not included in capitation:	4850.33
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment Capitated							
Caregiver/Family Supports and Services Total:							**4314600.00**
Caregiver/Family Support and Services	☐	Hour	4794	18.00	50.00	**4314600.00**	
Caregiver/Family Support and Services Capitated	☐	Hour	0	0.01	0.01	**0.00**	
Community Self-Advocacy Training and Supports Total:							**6089600.00**
Community Self-Advocacy Training and Supports	☐	Hour	2768	20.00	110.00	**6089600.00**	
Community Self-Advocacy Training and Support Capitated	☐	Hour	0	0.01	0.01	**0.00**	
Crisis Intervention Total:							**2535627.04**
Crisis Intervention	☐	15 mins	815	29.00	91.84	**2170638.40**	
Crisis Intervention per diem	☐	per diem	272	1.50	894.58	**364988.64**	
Environmental Modifications Total:							**1024000.00**
Environmental Modifications	☐	Project	160	1.00	6400.00	**1024000.00**	
Environmental Modifications Capitated	☐	Project	0	0.01	0.01	**0.00**	
Family Peer Support Services Total:							**3074720.00**
Family Support	☐	15 mins	1747	100.00	17.60	**3074720.00**	
Non-Medical Transportation Total:							**552600.00**
Non-Medical Transportation	☐	Trip	614	15.00	60.00	**552600.00**	
Palliative care - Expressive Therapy Total:							**27615.00**
Palliative care-Expressive Therapy	☐	Hour	263	3.00	35.00	**27615.00**	

GRAND TOTAL:	**56501527.04**
Total: Services included in capitation:	
Total: Services not included in capitation:	56501527.04
Total Estimated Unduplicated Participants:	**11649**
Factor D (Divide total by number of participants):	**4850.33**
Services included in capitation:	
Services not included in capitation:	4850.33
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Palliative care-Expressive Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care - Expressive Therapy	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Bereavement Service Total:							27675.00
Palliative care-Bereavement Service	☐	Hour	205	3.00	45.00	27675.00	
Palliative care-Bereavement Service Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Massage Therapy Total:							27720.00
Palliative care-Massage Therapy	☐	Hour	126	4.00	55.00	27720.00	
Palliative care-Massage Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Pain and Symptom Management Total:							27720.00
Palliative care-Pain and Symptom Management	☐	Hour	84	3.00	110.00	27720.00	
Palliative care-Pain and Symptom Management Capitated	☐	Hour	0	0.01	0.01	0.00	
Vehicle Modifications Total:							512000.00
Vehicle Modifications	☐	Project	80	1.00	6400.00	512000.00	
Vehicle Modifications Capitated	☐	Project	0	0.01	0.01	0.00	
Youth Peer Support and Training Total:							6089600.00
Youth Peer Support and Training	☐	15 mins	2768	20.00	110.00	6089600.00	
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	

GRAND TOTAL:	56501527.04
Total: Services included in capitation:	
Total: Services not included in capitation:	56501527.04
Total Estimated Unduplicated Participants:	11649
Factor D (Divide total by number of participants):	4850.33
Services included in capitation:	
Services not included in capitation:	4850.33
Average Length of Stay on the Waiver:	287

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							0.00
Case Management	☐	Hour	0	0.01	0.01	0.00	
Community Habilitation Total:							721656.00
Community Habilitation	☐	Hour	585	16.00	77.10	721656.00	
Community Habitation Capitated	☐	Hour	0	0.01	0.01	0.00	
Day Habilitation Total:							4077433.50
Day Habilitation	☐	15 mins	1511	35.00	77.10	4077433.50	
Day Habilitation Capitated	☐	15 mins	0	0.01	0.01	0.00	
Prevocational Services Total:							736150.80
Prevocational Services	☐	Hour	341	35.00	61.68	736150.80	
Prevocational Services Capitated	☐	Hour	0	0.01	0.01	0.00	
Respite Total:							35231616.00
Respite	☐	Hour	5712	100.00	61.68	35231616.00	
Respite Capitated	☐	Hour	0	0.01	0.01	0.00	
Supported Employment Total:							120276.00
Supported Employment	☐	Hour	26	50.00	92.52	120276.00	
Supported Employment Capitated	☐	Hour	0	0.01	0.01	0.00	

GRAND TOTAL:	58492309.16
Total: Services included in capitation:	
Total: Services not included in capitation:	58492309.16
Total Estimated Unduplicated Participants:	14515
Factor D (Divide total by number of participants):	4029.78
Services included in capitation:	
Services not included in capitation:	4029.78
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptive and Assistive Equipment Total:							**1150651.32**
Adaptive and Assistive Equipment	☐	Project	273	1.00	4214.84	**1150651.32**	
Adaptive and Assistive Equipment Capitated	☐	Project	0	0.01	0.01	**0.00**	
Caregiver/Family Supports and Services Total:							**5632617.60**
Caregiver/Family Support and Services	☐	Hour	6088	18.00	51.40	**5632617.60**	
Caregiver/Family Support and Services Capitated	☐	Hour	0	0.01	0.01	**0.00**	
Community Self-Advocacy Training and Supports Total:							**7949524.00**
Community Self-Advocacy Training and Supports	☐	Hour	3515	20.00	113.08	**7949524.00**	
Community Self-Advocacy Training and Support Capitated	☐	Hour	0	0.01	0.01	**0.00**	
Crisis Intervention Total:							**0.00**
Crisis Intervention	☐	15 min	0	0.01	0.01	**0.00**	
Crisis Intervention per diem	☐	Per Diem	0	0.01	0.01	**0.00**	
Environmental Modifications Total:							**1335589.78**
Environmental Modifications	☐	Project	203	1.00	6579.26	**1335589.78**	
Environmental Modifications Capitated	☐	Project	0	0.01	0.01	**0.00**	
Family Peer Support Services Total:							**0.00**
Family Support	☐	15 mins	0	0.01	0.01	**0.00**	
Non-Medical Transportation Total:							**721656.00**

GRAND TOTAL:	**58492309.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	58492309.16
Total Estimated Unduplicated Participants:	**14515**
Factor D (Divide total by number of participants):	**4029.78**
Services included in capitation:	
Services not included in capitation:	4029.78
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation	☐	Trip	780	15.00	61.68	721656.00	
Palliative care - Expressive Therapy Total:							36051.96
Palliative care-Expressive Therapy	☐	Hour	334	3.00	35.98	36051.96	
Palliative care-Expressive Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care - Expressive Therapy	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Bereavement Service Total:							36082.80
Palliative care-Bereavement Service	☐	Hour	260	3.00	46.26	36082.80	
Palliative care-Bereavement Service Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Massage Therapy Total:							35959.44
Palliative care-Massage Therapy	☐	Hour	159	4.00	56.54	35959.44	
Palliative care-Massage Therapy Capitated	☐	Hour	0	0.01	0.01	0.00	
Palliative care – Pain and Symptom Management Total:							35959.44
Palliative care-Pain and Symptom Management	☐	Hour	106	3.00	113.08	35959.44	
Palliative care-Pain and Symptom Management Capitated	☐	Hour	0	0.01	0.01	0.00	
Vehicle Modifications Total:							671084.52
Vehicle Modifications	☐	Project	102	1.00	6579.26	671084.52	
Vehicle Modifications Capitated	☐	Project	0	0.01	0.01	0.00	
Youth Peer Support and Training Total:							0.00

GRAND TOTAL:	58492309.16
Total: Services included in capitation:	
Total: Services not included in capitation:	58492309.16
Total Estimated Unduplicated Participants:	14515
Factor D (Divide total by number of participants):	4029.78
Services included in capitation:	
Services not included in capitation:	4029.78
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	
Youth Peer Support and Training	☐	15 mins	0	0.01	0.01	0.00	

GRAND TOTAL:	**58492309.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	58492309.16
Total Estimated Unduplicated Participants:	**14515**
Factor D (Divide total by number of participants):	**4029.78**
Services included in capitation:	
Services not included in capitation:	4029.78
Average Length of Stay on the Waiver:	287

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							0.00
Case Management	☐	Hour	0	0.00	0.01	0.00	
Community Habilitation Total:							902929.92
Community Habilitation	☐	Hour	538	16.00	79.26	682270.08	
Community Habitation Capitated	☒	Hour	174	16.00	79.26	220659.84	
Day Habilitation Total:							5101569.90
Day Habilitation	☐	15 mins	1388	35.00	79.26	3850450.80	
Day Habilitation Capitated	☒	15 mins	451	35.00	79.26	1251119.10	
Prevocational Services Total:							921030.25

GRAND TOTAL:	**72771474.54**
Total: Services included in capitation:	17610999.92
Total: Services not included in capitation:	55160474.62
Total Estimated Unduplicated Participants:	**17379**
Factor D (Divide total by number of participants):	**4187.32**
Services included in capitation:	1013.35
Services not included in capitation:	3173.97
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services	☐	Hour	313	35.00	63.41	694656.55	
Prevocational Services Capitated	☒	Hour	102	35.00	63.41	226373.70	
Respite Total:							44076291.00
Respite	☐	Hour	5248	100.00	63.41	33277568.00	
Respite Capitated	☒	Hour	1703	100.00	63.41	10798723.00	
Supported Employment Total:							152176.00
Supported Employment	☐	Hour	24	50.00	95.11	114132.00	
Supported Employment Capitated	☒	Hour	8	50.00	95.11	38044.00	
Adaptive and Assistive Equipment Total:							902641.35
Adaptive and Assistive Equipment	☐	Project	716	15.00	63.41	681023.40	
Adaptive and Assistive Equipment Capitated	☒	Project	233	15.00	63.41	221617.95	
Caregiver/Family Supports and Services Total:							7176209.22
Caregiver/Family Support and Services	☐	Hour	5594	18.00	53.81	5418236.52	
Caregiver/Family Support and Services Capitated	☒	Hour	1815	18.00	53.81	1757972.70	
Community Self-Advocacy Training and Supports Total:							9946350.00
Community Self-Advocacy Training and Supports	☐	Hour	3230	20.00	116.25	7509750.00	
Community Self-Advocacy Training and Support Capitated	☒	Hour	1048	20.00	116.25	2436600.00	
Crisis Intervention Total:							0.00
Crisis Intervention	☐					0.00	

GRAND TOTAL:	72771474.54
Total: Services included in capitation:	17610999.92
Total: Services not included in capitation:	55160474.62
Total Estimated Unduplicated Participants:	17379
Factor D (Divide total by number of participants):	4187.32
Services included in capitation:	1013.35
Services not included in capitation:	3173.97
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15-mins	0	0.00	0.01		
Crisis Intervention per diem	☐	Per Diem	0	0.01	0.01	0.00	
Environmental Modifications Total:							1670621.55
Environmental Modifications	☐	Project	186	1.00	6763.65	1258038.90	
Environmental Modifications Capitated	☒	Project	61	1.00	6763.65	412582.65	
Family Peer Support Services Total:							0.00
Family Support	☐	15-mins	0	0.01	0.01	0.00	
Non-Medical Transportation Total:							902641.35
Non-Medical Transportation	☐	Trip	949	15.00	63.41	902641.35	
Palliative care - Expressive Therapy Total:							45164.79
Palliative care-Expressive Therapy	☐	Hour	307	3.00	36.99	34067.79	
Palliative care-Expressive Therapy Capitated	☒	Hour	100	3.00	36.99	11097.00	
Palliative care - Expressive Therapy	☐	Hour	0	0.00	0.01	0.00	
Palliative care – Bereavement Service Total:							45086.88
Palliative care-Bereavement Service	☐	Hour	239	3.00	47.56	34100.52	
Palliative care-Bereavement Service Capitated	☒	Hour	77	3.00	47.56	10986.36	
Palliative care – Massage Therapy Total:							45101.12
Palliative care-Massage Therapy	☐	Hour	146	4.00	58.12	33942.08	
Palliative care-Massage Therapy Capitated	☒	Hour	48	4.00	58.12	11159.04	
Palliative care – Pain and Symptom							44981.01

GRAND TOTAL:	72771474.54
Total: Services included in capitation:	17610999.92
Total: Services not included in capitation:	55160474.62
Total Estimated Unduplicated Participants:	17379
Factor D (Divide total by number of participants):	4187.32
Services included in capitation:	1013.35
Services not included in capitation:	3173.97
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management Total:							
Palliative care-Pain and Symptom Management	☐	Hour	97	3.00	116.23	33822.93	
Palliative care-Pain and Symptom Management Capitated	☒	Hour	32	3.00	116.23	11158.08	
Vehicle Modifications Total:							838680.20
Vehicle Modifications	☐	Project	94	1.00	6763.55	635773.70	
Vehicle Modifications Capitated	☒	Project	30	1.00	6763.55	202906.50	
Youth Peer Support and Training Total:							0.00
Youth Peer Support and Training	☐	15-mins	0	0.00	0.01	0.00	
Youth Peer Support and Training	☐	15 mins	0	0.00	0.01	0.00	

GRAND TOTAL:	72771474.54
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